The PG&E Corporation

Disability Plan

Handbook

For Employees of PG&E Corporation

January, 2004

Revised 7/1/04

The information contained within this handbook is intended as a summary only and describes the Short Term and Long Term Disability programs; known collectively as the ***PG&E Corporation Disability Plan***. Although detailed in nature, this handbook has been designed to provide the reader with an **overview** of the ***PG&E Corporation Disability Plan*** (referred to in this handbook as "***the Disability Plan***" or "the ***Disability program***" or "the Plan" or "Plan") Because it is an overview, it does not include all of the important legal definitions or limitations that are in the Plan document or contracts governing your benefits. Therefore, this handbook does not replace those legal documents and, in case of conflict, those legal documents govern your benefits.

The ***Disability*** program is sponsored by PG&E Corporation. PG&E Corporation has entered into an insurance contract with Liberty Mutual that provides for Liberty Mutual to assume full responsibility and liability for the determination and payment of benefits. Liberty Mutual insures the benefits described in this handbook. All benefits becoming due under the ***Disability*** program are funded by Liberty Mutual.

Since future conditions affecting PG&E Corporation cannot be foreseen, PG&E Corporation reserves the right to amend, modify, or terminate the Plan, or programs that are part of the Plan, at any time. Although any change or termination of the Plan or a program that is part of the Plan will not affect the benefits paid to participants before the date the Plan or program was changed or terminated, such change may result in reduced levels of benefits or benefit coverage, or increased employee contributions, after the effective date of any such change.

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Introduction

PG&E Corporation is dedicated to being the premier energy services company. To offer you a benefits package that is cost effective and competitive, your employee benefit program is provided through two sources: ***PG&E Corporation*** and ***Pacific Gas and Electric Company*** (Utility).

- Your disability benefits are provided through the ***PG&E Corporation Disability Plan*** and your Paid Time Off (PTO) is provided under the PG&E Corporation PTO policy
- Your health care, dental care, vision, employee assistance, reimbursement accounts, and other benefits are provided through the Utility's plans and programs.

The information included in this handbook describes your disability benefits. For information on your PTO benefits, you should refer to PG&E Corporation's PTO policy. For information on the benefits provided through the Utility, you should refer to PG&E Corporation's Benefits Highlight document and the Utility's Summary of Benefits Handbook for Management and Administrative & Technical Employees[1] (Please note, information in the Utility's Summary of Benefits Handbook describing "Vacation" in the "Time Off" section and the entire "Sick Leave and Disability" section do not apply to employees of PG&E Corporation.)

About Your Disability Benefits

PG&E Corporation provides you with income replacement benefits during both short-term and long-term disabilities. The ***Disability*** programs work together with state and federally required programs to provide you with a steady source of income. The programs include:

- ***Short Term Disability (STD)*** – ***STD*** program benefits are insured by Liberty Life Assurance Company of Boston, a Liberty Mutual company ("Liberty Mutual"). Benefits are paid as of the:
  - First day of a hospitalization or injury (see "*Hospitalization*" under "*Important Definitions*")
  - 8th consecutive day of an illness

  PG&E Corporation pays the full cost for the ***STD*** program.
- ***Sick Leave Bank –*** If you:
  - Were previously covered by a PG&E Corporation Sick Pay and Vacation Pay program that transitioned into a Paid Time Off (PTO) program, or
  - Transferred from Pacific Gas & Electric Company to PG&E Corporation,

  Some or all of your accumulated Sick Pay was placed in a frozen Sick Leave Bank. If you have a Sick Leave Bank, you may use sick pay to supplement Short Term Disability Payments. See "*How the Disability Program Works*" for additional information.
- ***Long-Term Disability (LTD) –*** ***LTD*** program benefits are insured by Liberty Life Assurance Company of Boston, a Liberty Mutual company ("Liberty Mutual"). Benefits are paid after 6 months of a disability. PG&E Corporation pays the full cost for the ***LTD*** program.
- ***State and Federally Required Programs***

[1] Including all summaries of changes/modifications issued after the publication date of January, 2003.

- ***State Disability Insurance (SDI)*** — California, New Jersey, New York and Rhode Island have state required disability programs. If you live in a state that has a required disability program, your cost to participate in the program is deducted from your paycheck
- ***Workers' Compensation*** — Workers' Compensation benefits are insured by AIG. Benefits are paid for work-related injuries or illnesses. PG&E Corporation pays the full cost for Workers' Compensation Benefits
- ***Social Security Disability Benefits (SSDA)*** – Benefits are paid after 5 months of a severe disability. Both you and PG&E Corporation contribute toward the cost of SSDA

For information on how PG&E Corporation's ***Disability Programs*** work with these State and Federally required programs, see *How Benefits are Calculated – Benefit Offset*s under *How the Disability Program Works*.

This handbook only describes the *STD* and *LTD* benefits insured by Liberty Life Assurance Company of Boston (referred to as "Liberty Mutual"). For information about:

- The Sick Leave Bank – review PG&E Corporation's *Paid Time Off* policy
- A State Disability Insurance program – contact your state's insurance department that administers the disability program
- Workers' Compensation – contact PG&E Corporation's Human Resources Department
- Social Security Benefits – contact the nearest office of the Social Security Administration or call their toll free number 1-800-772-1213

Eligibility

You are eligible for the ***STD*** and ***LTD*** programs immediately if you are a full-time or part-time employee of PG&E Corporation. This immediate coverage is for you, the employee, only. The ***STD*** and ***LTD*** programs do not cover family members.

You are not eligible for the ***STD*** program or the ***LTD*** program if you are:

- A contract or agency employee,
- An employee of any PG&E Corporation subsidiary or affiliated company whose participation has not been approved by PG&E Corporation's Board of Directors.

Participation

If you meet the eligibility requirements, you are automatically a participant in the ***STD*** and ***LTD*** programs. You do not need to complete an enrollment form but you must be actively at work for your participation to begin. See "*Actively at Work*" for additional information.

Actively at Work

You must be actively at work on the day you become eligible for participation in the ***STD*** and ***LTD*** programs. For the purpose of the ***STD*** and ***LTD*** programs, Actively at Work means:

- For new hires – You report to work on your first day of employment and work your normal scheduled hours
- For employees who become eligible for ***the Disability Plan*** due to a change in hours or transfer from a non-eligible position to an eligible position – You report to work on your first day of becoming an Eligible Employee and work your normal scheduled hours **unless** you are absent because:
  - That day is a company paid holiday or a Paid Time Off day
  - That day is a non-scheduled work day
  - You are on an approved leave of absence for reasons other than a medical leave due to your own illness or injury or lay-off **and** you worked on the day before the absence

The actively at work provision does not apply to employees of PG&E Corporation who, on January 1, 2004, are receiving or are entitled to receive STD or LTD benefits from a PG&E Corporation sponsored disability plan.

Your Authorization and Certification

By being enrolled in the programs that make up ***the Disability Plan:***

- You automatically authorize PG&E Corporation to disclose your social security number to third-party administrators and insurers, as required, for purposes of Plan and program administration.
- You understand that PG&E Corporation reserves the right to amend, suspend, or terminate the Plan or any part of the Plan or the programs described in this handbook at any time.

When Participation Ends

Your active participation ends on the earlier of the day your employment terminates or the day you no longer meet the eligibility requirements.

Changing Your Address

If you move or want to change your mailing address, you must notify PG&E Corporation's Human Resources Department.

Help is a Phone Call Away

If you have any questions about ***the Disability Plan***, call PG&E Corporation's Human Resources Department at 415-267-7004.

Summary of Benefits

The following is a high level summary of some of the key provisions of the ***STD*** and ***LTD*** programs. Detailed information is included under "*How the Disability Program Works*".

Provision	***STD***	***LTD***
Benefit Waiting Period ("Elimination Period")	The period of time you must be disabled before benefit payments begin	
	➢ No waiting period for disabilities caused by an injury or if hospitalized ➢ 7 days for an illness	➢ 180 days
Benefit Amount	Based on Weekly Base Earnings	Based on Monthly Base Earnings
➢ Percentage of Pay	66 2/3%	66 2/3%
➢ Maximum Benefit	$2,564/week	$11,111/month
➢ Minimum Benefit	None	$100
Maximum Benefit Period (Earlier of)	➢ End of the disability ➢ 26 weeks of disability (180 days)	➢ End of disability ➢ Age 65 or after, depending on your age when the disability began ➢ 24 months for disabilities due to Mental Illness or Alcohol or Drug Abuse

How the Disability Program Works

The ***STD*** program and the ***LTD*** program are designed to provide you with a level of income replacement during periods of disability and, in some cases, a partial disability.

The amount of benefit is based on your pre-disability earnings and benefits from other sources, called benefit offsets. A description of *Pre-Disability Earning* and *Benefit Offsets* is included in "*How Benefits are Calculated*" under "*How the Disability Program Works*".

The length of time you receive disability benefits is based on the cause of the disability and the age when the disability begins.

Liberty Mutual insures the ***STD*** and ***LTD*** programs. Liberty Mutual determines if you are disabled and eligible to receive benefits. To receive disability benefits, you must meet all of Liberty Mutual's requirements.

The following information should help you understand the requirements and how the ***STD*** and ***LTD*** programs work. There are four major provisions that you need to understand about the ***STD*** and ***LTD*** programs. They are:

- Who is eligible to receive disability benefits
- What "disability" means
- How your benefits are calculated
- How long you may receive benefits

Who is Eligible to Receive Disability Benefits

You are eligible to receive ***STD*** benefits if you meet Liberty Mutual's definition of disability. You are eligible to receive ***LTD*** benefits if you meet Liberty Mutual's definition of disability but the disability is not due to a pre-existing condition.

Pre-Existing Condition

Only the ***LTD*** program has a pre-existing condition provision. A pre-existing condition does not effect your eligibility to received ***STD*** program benefits.

A pre-existing condition is an illness or injury that was diagnosed or treated within three (3) months before the date you become eligible to participate under ***the Disability Plan*** or the predecessor LTD benefit program that was part of PG&E Corporation's ***FlexAbility Plan***. If you have a pre-existing condition that causes or contributes to your disability, your eligibility to receive ***LTD*** program benefits is based on when your disability begins. If you become disabled:

- During the first 12 months that you are a participant in the ***LTD*** program, you *will not* be eligible to receive ***LTD*** program benefits, even if you meet the program's definition of disability
- After the first 12 months that you are a participant in the ***LTD*** program, you *will* be eligible to receive ***LTD*** program benefits, if you meet the program's definition of disability

Special Transition Provision

If you transfer from the Utility to PG&E Corporation, the following special transition provisions apply if you cannot meet this ***LTD*** program's Pre-Existing Conditions requirements, this program will use your prior program's definition of a pre-existing conditions exclusion and will count the continuous time you are insured by both programs to satisfy the prior program's exclusion if you:

- Meet the requirements by counting the continuous time you are insured by both policies and you meet this programs' definition of disability, you ***will*** be eligible to receive benefits from this program
- Do not meet the requirements by counting the continuous time you are insured by both policies, you ***will not*** be entitled to receive benefits from this ***LTD*** program.

What "Disability" Means

Total Disability – Short Term

The definition of *total disability* (or *disabled*) for the ***Short Term Disability*** program, is:

> Due to an illness or injury, you are not able to perform all of the material and substantial duties of your job at PG&E Corporation.

Total Disability – Long Term

The definition of *total disability* (or *disabled*) for the ***Long Term Disability*** program, is:

> Due to an illness or injury, you are not able to perform all of the material and substantial duties of:

- Your occupation at PG&E Corporation, during the Benefit Waiting Period and the 24 month benefit payment period following the Benefit Waiting Period
- Your occupation at PG&E Corporation or any other occupation which, through training, education, experience, age and physical and mental capacity, you can reasonably be expected to do after the 24 month payment period.

In other words, you will be considered disabled if you cannot do your occupation at PG&E Corporation during the first 30 months of disability (6 month waiting period plus 24 months of payment) or any comparable occupation, whether or not for PG&E Corporation, after that period. This is referred to as an Own Occupation/Any Occupation provision that is common in disability programs.

Partial Disability

The programs also recognize a *partial disability*. The definition of *partial disability* (or *partially disabled*) for ***STD*** and ***LTD*** is:

- You are able to perform one or more, but not all, of the material and substantial duties of your own job at PG&E Corporation or any job, on a full time or part time basis, and are paid regular earnings
- You are able to perform, on a part time basis, all of the material and substantial duties of your own job at PG&E Corporation or any job

How Benefits are Calculated

The calculation for the ***STD*** program and ***LTD*** program is:

66 2/3%	**X**	Your Pre-Disability Earnings	–	The Benefit Offsets

STD program benefits are paid weekly. The maximum ***STD*** program benefit is $2,564 per week. If a payment is for a period of less than a full week, you will receive 1/7th of the weekly amount for each day you are entitled to receive a benefit payment.

LTD program benefits are paid monthly. The maximum ***LTD*** program benefit is $11,111 per month. If a payment is for a period of less than a full month, you will receive 1/30th of the monthly amount for each day you are entitled to receive a benefit payment.

Percentage of Pre-Disability Earnings

The 66 2/3% of Pre-Disability Earnings is an amount approved by PG&E Corporation as the program's income replacement goal when combined with other income replacement benefits.

Pre-Disability Earnings

Pre-Disability Earnings are the amount of pay you **actually receive** during the week (for ***STD***) or month (for ***LTD***) immediately before the date your disability begins. Pre-Disability Earnings do not include bonuses, commissions, overtime pay and extra compensation.

For example, if your annual rate of pay is $40,000, and you are a full time employee, your Pre-Disability Earnings would be:

Your weekly Pre-Disability Earnings for ***STD*** benefits would be:

$40,000	÷	52 Weeks	=	$769.23

And your monthly Pre-Disability Earnings for ***LTD*** benefits would be:

$40,000	÷	12 Months	=	$3,333.34

Benefit Offsets

The goal of the ***STD*** and ***LTD*** programs is to replace 66 2/3% of your Pre-Disability Earnings, when combined with all other disability and retirement benefits. To accomplish that goal, both programs offset (which means reduce) the amount of benefit they pay by the amount you receive or are entitled to receive from other sources. The Benefit Offsets are:

Benefit Offsets	
Short Term Disability Program	**Long Term Disability Program**
All disability benefits under the United States Social Security Act (*for you only*)	All disability and/or retirement benefits under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar program or act (*for you and amounts for your family members*)
All benefits paid under Workers' Compensation law or any other act or law of like intent	All benefits paid under Workers' Compensation law or any other act or law of like intent
All benefits from any other governmental program or coverage required or provided by statute such as state disability insurance or programs that replace state disability insurance (*for you and amounts for your family members*)	All benefits from any other governmental program or coverage required or provided by statute such as state disability insurance or programs that replace state disability insurance (*for you and amounts for your family members*)
50% of the amount of pay you earn or receive from any form of employment	All pay you earn or receive from any form of employment
	All disability benefits from any other plan or program sponsored by PG&E Corporation

Other Information About Benefit Offsets

For purposes of calculating your ***STD*** or ***LTD*** benefit:

- After the first deduction for each of your benefits from "other sources", your monthly benefit will not be further reduced due to any cost of living increases paid by the "other source". This provision does not apply to increases received from any form of employment.
- If you receive benefits from an "other source" which are paid in a lump sum, the benefit will be prorated on a monthly basis over the time period for which the sum is given, or the STD or LTD maximum benefit period, whichever is less.

Disability Benefits

Here is an example of how ***STD*** and ***LTD*** benefits are calculated.

In this example, Mary earns $40,000/year, which is $769.23/week, or $3,333.33/month. Mary receives $150.00/week or $650.00/month in state disability.

Mary's weekly STD benefit would be:								Benefit Amount
$769.23	X	.667	=	$513.08	–	$150.00	=	*$363.08*
Mary's monthly LTD benefit would be:								
$3,333.33	X	.667	=	$2,223.33	–	$650.00	=	*$1,573.33*

Partial Disability Benefits

STD Program

To qualify for partial disability benefits you must meet all of the following requirements:

- You received disability benefits from ***this plan*** or the predecessor STD benefit program that was part of PG&E Corporation's ***FlexAbility Plan***
- Your partial disability began within 31 days of the date your disability benefits ended
- You returned to work, whether or not for PG&E Corporation, but your earnings are less than 80% of your Pre-Disability Earnings
- You submit proof of your partial disability acceptable to Liberty Mutual
- You are under the regular care of a physician

If you meet the requirements for a partial disability you will receive a STD benefit equal to the lesser of:

- 50% of your regular weekly STD benefit
- Your Pre-Disability Earnings less any Benefit Offsets and any earnings you receive while Partially Disabled.

Example:

Mary earned $40,000/year or $769.23/week before she became disabled. She received $150.00 a week from her state disability insurance program and $363.08 per week in regular *STD* benefits for a total of $513.08. Mary returns to work on a part time basis and earns 40% of her pre-disability earnings, $307.70. Because Mary returned to work on a part time basis, her state disability insurance program benefit was reduced to $75.00.

- **50% of Mary's regular weekly *STD* benefit is: $256.54**
  $769.23 x .667 (benefit %) = $513.08 x 50%= $256.54
- **Mary's pre-disability earnings less benefit offsets and her earnings are: $386.53**
  $769.23 – ($75.00 + $307.70) = $386.53

The lesser of the two calculations is $256.54 so Mary will receive $256.54 in partial disability benefits, $75.00 in state disability benefits, and her earnings of $307.70 for a total of $639.24.

LTD Program

To qualify for partial disability benefits you must meet all of the following requirements:

- You must satisfy the ***LTD*** program Elimination Period
- You are employed and you earn at least 20% of your Pre-Disability Earnings
- If the partial disability is due to an injury, the injury must have happened while you are covered by ***this Plan*** or the predecessor LTD benefits program that was part of PG&E Corporation's ***FlexAbility Plan***
- You submit proof of your partial disability acceptable to Liberty Mutual
- You are under the regular care of a physician

If you meet the requirements for a partial disability, you will receive ***LTD*** benefits equal to the following:

- During the first 12 months, you will receive a monthly benefit equal to your Pre-Disability Earnings times 66 2/3%. This amount will be reduced if your earnings plus your Partial Disability benefit are greater than your Pre-Disability Earnings. If that is the case, your Partial Disability benefits will be reduced so that the combination of Partial Disability benefits plus your earnings equal your Pre-Disability Earnings.
- After the first 12 months, your Partial Disability benefit will be the lesser of:
  - 75% of the difference of your Pre-Disability Earnings and your pay minus the Benefit Offsets,
  - 66 2/3% times your Pre-Disability Earnings minus the Benefit Offsets

Example:

Mary earned $40,000/year or $3,333.33/month before she became disabled. She received $650.00 a month from her state disability program and $1573.33 per month in regular *LTD* benefits for a total of $2,223.33.

Mary returns to work on a part time basis and earns 40% of her pre-disability earnings, $1333.33. Because Mary returned to work on a part time basis, her state disability insurance program benefit was reduced to $325.00 per month.

For the first 12 months of benefits after Mary's return to partial employment, her *LTD* benefit will be her pre-disability earnings multiplied by the Benefit Percent, without any reductions from earnings unless her monthly benefit plus earnings exceed 100% of the pre-disability earnings. In that instance they would be reduced to 100%.

(1) Mary's disability income before she returns to partial employment	$2,223.33
(2) Plus Mary's earnings from partial employment	$1,333.33
(3) Total of (1) and (2)	$3,556.66
(4) Subtract Mary's pre-disability earnings of $3,333.33,	-$3,333.33
(5) If (4) is less than (3) subtract (4) from (3), if (4) is equal to or more than (3), enter zero – this is the amount of Mary's partial employment earnings that will be used to offset Mary's disability income before she returned to partial employment	$223.33
(6) Enter Mary's disability income before she returned to partial employment (1)	$2,223.33
(7) Subtract Mary's earnings offset (5)	-$223.33
(8) Subtract Mary's monthly state disability benefit	-$325.00
(9) Total (6), (7), and (8) – this is Mary's partial disability benefit	**$1,675.00**

For the first 12 months, Mary will receive $1,675.00 in partial disability benefits, $325.00 in state disability, and her earnings of $1,333.33 for a total of $3,333.33.

After the first 12 months, Mary's benefit would be calculated as follows:

(1) Mary's pre-disability earning	$3,333.33
(2) Subtract Mary's earnings from partial employment	-$1,333.33
(3) Total of (1) and (2)	$2,000.00
(4) Multiply (3) by 75% (.75)	$1,500.00
(5) Enter Mary's disability benefit before partial employment (#1) from the first example)	$2,223.33
(6) Enter the lesser of (4) or (5)	$1,500.00
(7) Subtract Mary's benefit offsets	-$325.00
(8) This is Mary's disability benefit after the first 12 months of partial employment	**$1,175.00**

After the first 12 months of partial employment, Mary would receive $1,175.00 in partial disability benefits, $325.00 in state disability, and her earnings of $1,333.33 for a total of $2,833.33.

How Long Benefits are Paid

STD and ***LTD*** benefits are paid until the earlier of:

- The end of your disability or partial disability, or when you no longer meet the definitions and requirements of a disability or partial disability. See *"What 'Disability' Means"* and *"Partial Disability Benefits" for additional information.*
- The date you die

- If you are partially disabled, the date your current earnings are greater than 80%[1] of your Pre-Disability Earnings (applies only to ***STD*** benefits)
- The end of your Maximum Benefit Period (See "*Maximum Benefit Period*" for additional information)

Maximum Benefit Periods

Short Term Disability

The Maximum Benefit Period for ***STD*** benefits is:

- 26 weeks of disability if your disability was caused by an injury or if you were hospitalized on the day your disability began
- 25 weeks of disability if your disability is caused by an illness and you were not hospitalized on the day your disability began

Long Term Disability

For disabilities that begin before July 1, 2004, the Maximum Benefit Period for ***LTD*** benefits is based on your age when the disability begins, as shown in the following chart:

Age When Disability Begins	LTD Maximum Benefit Period	
Less than age 61	To the greater of: ➢ Your Social Security Normal Retirement Age (see "Social Security Normal Retirement Age" chart) ➢ Age 65 But not less than 60 months (5 years)	
61	48 months	(4 years)
62	42 months	(3 ½ years)
63	36 months	(3 years)
64	30 months	(2 ½ years)
65	24 months	(2 years)
66	21 months	(1 ¾ years)
67	18 months	(1 ½ years)
68	15 months	(1 ¼ years)
69 and over	12 months	(1 year)

1 Because your earnings may fluctuate, Liberty Mutual may average your earnings over three (3) consecutive months rather than immediately ending your benefit once you reach the 80% level.

For disabilities that begin on or after July 1, 2004, the Maximum Benefit Period for ***LTD*** benefits is based on your age when the disability begins, as shown in the following chart:

Age When Disability Begins	LTD Maximum Benefit Period	
Less than age 61	To the greater of: ➢ Your Social Security Normal Retirement Age (see "Social Security Normal Retirement Age" chart) ➢ Age 65 But not less than 60 months (5 years)	
61 and over	60 months	(5 years)

Your Social Security Normal Retirement Age is based on the year of your birth, as follows:

Year of Birth	Social Security Normal Retirement Age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and after	67

Mental Illness and Alcohol or Drug Abuse

If your disability is caused by a mental nervous or emotional disease disorder or from alcohol or drug abuse the ***LTD*** benefit payment period will not exceed 24 months unless you meet one of the following situations:

- You are in a hospital or institution of mental illness or alcohol or drug abuse at the end of the 24 month period, you will continue to receive the monthly ***LTD*** benefit during your period of confinement.

  If you are still disabled when you are discharged, the monthly ***LTD*** benefit will be paid for a recovery period of up to 90 days. If you become re-confined during the recovery period for at least 14 consecutive days, benefits will be paid for the re-confinement and one additional recovery period of up to 90 more days.

- You are not confined in a hospital or institution but continue to be disabled and become confined for the mental illness or alcohol or drug abuse after the 24 month period and for at least 14 days in a row benefits will be paid for the period of confinement and a subsequent recovery period of up to 90 days.

Benefits will not be paid beyond the Maximum Benefit Period.

What You Must Do to Receive Benefits

To be eligible to receive disability benefits you must:

- Meet Liberty Mutual's definition of Disability
- Be under the regular care of a medical doctor and
- You or a family member must notify Liberty Mutual within 30 days from the date of an injury or the onset of an illness.

See "*Claims & Appeals Information*" for additional information.

If your claim is approved, you may be asked from time to time to submit supplemental information supporting your ongoing disability. You must supply this information to continue to be eligible to receive benefits.

The cost, if any, of submitting information regarding your claim is your responsibility.

Important Things You Should Know About the *Disability* Program

Definitions

Elimination Period

The Elimination Period is the period of consecutive days between the day you become disabled and the time benefits begin – it is a benefit waiting period.

During the ***LTD*** Elimination Period, if you return to work for 30 days or less but can not continue to work, only the days you are disabled (not the period while you returned to work) will count toward your Elimination Period.

Hospitalization

For the purpose of ***STD*** benefits hospitalization means formally admitted to a hospital for in-patient treatment. The hospital admission can be for a full day or overnight. Hospitalization does not include treatment:

- In an emergency room
- In a dentist's office
- A place that is mainly for drug addiction or alcoholism
- A place that is mainly utilized as a nursing home

Injury and Illness

Injury means an impairment that directly results from an accident and separately from all other causes. If a disability begins more than 60 days after an injury, it will be considered an Illness for ***STD*** and ***LTD*** program purposes.

Illness means a sickness, disease, pregnancy, or complications of pregnancy.

Medical Examinations

If you file a claim for benefits or if you are receiving benefits, Liberty Mutual, at their expense, has the right to have you examined by a physician or vocational expert of their choice. This right may be used as often as Liberty Mutual determines is reasonably required. If you do not agree to an examination, your eligibility for benefits will end.

Successive Periods of Disability

If you receive disability benefits under this ***STD*** or ***LTD*** program, or the predecessor STD or LTD programs that were part of PG&E Corporation's ***FlexAbility Plan***, and you return to work and then become disabled again due to the same or a related cause(s) as your prior disability, you may qualify for a Successive Period of Disability. If you qualify for a Successive Period of Disability, it will be treated as part of your prior disability, and benefits will begin immediately – you will not be required to meet a new Elimination Period.

To qualify for a Successive Period of Disability, you must have:

- Received ***STD*** benefits immediately before you returned to work in your own job at PG&E Corporation for a period of **less than 2 consecutive weeks** or,
- Received ***LTD*** benefits immediately before you returned to work in your own job at PG&E Corporation for a period of **less than 6 consecutive months**, and
- Performed all of the material and substantial duties of your own job.

If you return to work for a period of time that is longer than those described above, any future disability will be considered new and you will be required to meet a new Elimination Period.

Survivor Benefits

The ***LTD*** program includes a survivor benefit if:

- You die while receiving monthly ***LTD*** benefits, and
- Your disability continued for 180 or more consecutive days

The amount of survivor benefit is six (6) times your last monthly benefit. Your last monthly benefit means the net benefit you received but, if you were partially disabled, without any reduction for earnings from employment.

Survivor benefits will be paid in a lump sum, and in the following order:

- To your surviving spouse or domestic partner that is registered internally with the company or externally with a governmental agency that has a registry program.
- To your children under the age of 25 in equal shares or to a person identified by Liberty Mutual to be the guardian of the children's property

If payment is made to a guardian, it will be valid and effective against all claims by others representing or claiming to represent the children

- To your estate

Taxability of Benefits

The ***STD*** and ***LTD*** benefits, including survivor benefits, are taxable income because the premium is paid by PG&E Corporation. You may instruct Liberty Mutual to withhold federal and state taxes and, each year, Liberty Mutual will send you an IRS Form 1099 reporting the amount you received and the amount of taxes withheld.

Limitations and Exclusions

Disabilities Not Covered

The ***STD*** or ***LTD*** programs will not cover any disability due to:

- War, declared or undeclared or any act of war
- Intentionally self-inflicted injuries, while sane or insane
- Active Participation in a Riot
  Participation includes promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but does not include actions taken in defense of public or private property, or actions taken in defense of yourself, if such actions of defense are not taken against a person or persons seeking to maintain or restore law and order including, but not limited to police officers and firemen.

  Riot includes all forms of public violence, disorder or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of the disorder.
- Your committing of or the attempting to commit an indictable offense

Late Claims

The ***STD*** and ***LTD*** programs will not pay benefits for any claim filed later than 13 months following the onset of a disability, unless you were not able to file the claim due to the absence of legal capacity.

Claims & Appeals Information

PG&E Corporation provides benefit information to participants in several different formats, including this ***Summary of The Disability Plan*** handbook and annual open enrollment material. ***It is your responsibility to read all information that is supplied.*** If you have questions or would like more detailed information on benefits, please call PG&E Corporation's Human Resources Department.

Filing a Claim for Benefits

To be eligible to receive disability benefits you must meet Liberty Mutual's definition of disability, be under the regular care of a medical doctor and you or a family member must notify Liberty Mutual within 30 days from the date of an injury or the onset of an illness.

Liberty Life Assurance Company of Boston
Disability Claims
P. O. Box 37500
Phoenix, AZ 85069

To receive a claim form, call PG&E Corporation's Human Resources Department. Once your claim form is completed, send it to Liberty Mutual at the above address.

Liberty Mutual will notify you if your claim for disability benefits is approved or denied as soon as is reasonably possible. If your claim is denied you will be notified no later than 45 days from the date your claim is received. This 45-day period may be extended for up to 30 days, if Liberty Mutual

- Determines the extension is necessary because of matters beyond their control (such as missing medical information), and
- Notifies you, before the end of the 45-day period, why the extension is needed, and the expected decision date.

If, before the end of the first 30-day extension, Liberty Mutual determines, due to matters beyond their control, a decision cannot be made within the extension period, the determination period may be extended for up to an additional 30 days. Liberty Mutual will notify you, before the end of the first 30-day extension period, why the additional extension is needed, and the expected decision date.

The notice of extension will explain:

- The standard on which benefit entitlement is based
- The unresolved issues that prevent a claim decision
- The additional information that is needed
  You have at least 45 days to provide the additional information.

The claim determination time frames begin when a claim is filed, without regard to whether all the information necessary to make a claim determination is included. If an extension is necessary because you fail to submit necessary information, the days from the date Liberty Mutual sends you the extension notice until you respond to the request for additional information are not counted as part of the claim determination period.

If Liberty Mutual does not approve your claim, you will receive a written notice. The written notice of denial will include:

- The specific reason or reasons for denial with reference to those specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why that material or information is necessary;
- A description of the Plan's appeal procedures and time frames, including a statement of the claimant's right to bring a civil action under ERISA following an adverse decision on appeal;
- If applicable, any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and a copy thereof will be provided free of charge upon request; and

- If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.

If Liberty Mutual does not approve your claim, you, or your authorized representative, may appeal the denied claim within 180 days after you receive Liberty Mutual's notice of denial. See "*Appeals*" below.

Appeals

Although you are not precluded from submitting any written claim or appeal, determinations on your claims will be made on the basis of Plan and program provisions. As an alternative to submitting a claim or appeal for benefits not included under the provisions of the Plan or a program, you may submit written correspondence to the Plan Administrator suggesting changes that could be made in the future. (Please be sure to make it clear that your correspondence is a suggestion on changes, not an appeal for benefits under current Plan or program provisions.) See "*Plan Administrator*" under "*For the Record*" for additional information.

If you believe you are not receiving a benefit to which you may be entitled under the provisions of the Plan or a benefit program, there are avenues for you to submit appeals. For appeals relating to:

- Your **eligibility to participate** in ***the Disability Plan*** or a program that is part of ***the Disability Plan,*** you should follow the process outlined under "*Eligibility & Participation Appeals*"
- The **denial of a disability benefit**, in whole or in part, or if you disagree with the amount of disability benefit you receive, you should follow the process outlined under "*Benefit Determination Appeals*"

Eligibility & Participation Appeals

If you believe you have been incorrectly denied eligibility to participate in ***the Disability Plan*** or a program that is part of ***the Disability Plan***, you should first contact PG&E Corporation's Human Resources Department to discuss your concerns. If you cannot resolve your concern, then you may submit a formal appeal to the Plan Administrator by following the process described below.

Initial Appeal

The Plan Administrator has appointed the Senior Director of Compensation, Benefits, and HRIS of PG&E Corporation to perform the initial review of an appeal and make a determination. Your appeal should be addressed to:

Senior Director of Compensation, Benefits and HRIS
c/o the Plan Administrator
PG&E Corporation
Human Resources Dept., Suite 400
One Market, Spear Tower
San Francisco, CA 94105

No special form or format is required in submitting a written appeal; you may submit written comments, documents, and other information in any words which you believe will further your appeal. Please note, however, that it is the obligation of the Senior Director of Compensation, Benefits, and HRIS to administer the Plan and programs that make up the Plan fairly, consistently, and in accordance with the provisions of the Plan and the programs.

The Senior Director of Compensation, Benefits, and HRIS must respond to you within 90 days of receipt of your appeal unless, due to special circumstances, the Senior Director of Compensation, Benefits and HRIS requires additional time to respond (up to another 90 days).

If the Senior Director of Compensation, Benefits, and HRIS denies your claim, you will receive a written response that will include:

- Reasons for the denial of the claim
- A reference to the Plan and/or program provisions that apply to the denial
- A description of any material or information you may need to obtain approval of your claim, if appropriate, and why the information or material is needed
- A description of the Plan's review procedures and the time limits applicable to the procedures
- A statement of your, or your beneficiary's, right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review

If you are not satisfied with the Senior Director of Compensation, Benefits, and HRIS's decision, you may then submit a written appeal to PG&E Corporation's Claims Review Committee (the Committee). See "*Final Appeal*".

Final Appeal

If you are not satisfied with the decision of the Senior Director of Compensation, Benefits, and HRIS, you may then submit a written appeal to PG&E Corporation's Claims Review Committee (the Committee) who has been delegated the authority to review appeals and make determinations on behalf of PG&E Corporation. The Committee's decision is final in the eligibility and participation appeals process.

Your written appeal should state the reasons for your appeal and should include copies of all documentation and any additional information to support your appeal. Your appeal should be addressed to:

Claims Review Committee
c/o Senior Director of Compensation, Benefits and HRIS
PG&E Corporation
Human Resources Dept., Suite 400
One Market, Spear Tower
San Francisco, CA 94105

Your appeal must be received by the Committee within 60 days of receiving the written denial of your claim from the Senior Director of Compensation, Benefits, and HRIS. No special form or format is required in submitting a written appeal; you may submit written comments, documents, and other information relating to your claim. The review of your appeal will take into account all comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered during the initial appeal. Please note, however, that it is the obligation of the Committee to administer the Plan and the programs that make up the Plan fairly, consistently, and in accordance with the provisions of the Plan and the programs.

You will receive a **final written response** from the Committee within 60 days of the Committee's receipt of your appeal unless, due to special circumstances, the Committee requires additional time to respond, up to another 60 days.

The written response will include:

- Reasons for the denial of the claim
- A reference to the Plan and/or program provisions that apply to the denial

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for eligibility or participation

If, after exhausting the appeal process, you, or your beneficiary, are still not satisfied with the outcome, you have the option of taking legal action under section 502(a) of ERISA.

Benefit Determination Appeals

Liberty Mutual is responsible for determining covered benefits under the ***Disability*** program and making **all** decisions regarding the appeal of **all** adverse benefit determinations. Decisions made by Liberty Mutual are final. PG&E Corporation does not review these appeals.

If your claim for a benefit is denied, in whole or in part, or if you disagree with the amount of benefit you receive, although not required, you should first discuss your concerns by contacting Liberty Mutual at 1-800-320-7585. If Liberty Mutual cannot resolve your concerns, or if you do not want to discuss your concerns with Liberty Mutual, you or your authorized representative, may appeal the denied claim within 180 days after you receive Liberty Mutual's notice of denial by following the process described below.

You have the right to:

- Submit to Liberty Mutual for review, written comments, documents, records and other information relating to your claim
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim
- A review that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim decision
- A review that does not afford deference to the initial adverse decision and which is conducted neither by the individual who made the adverse decision nor that person's subordinate
- If the appeal involves an adverse decision based on medical judgment, a review of your claim by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the adverse decision nor the subordinate of any such individual
- The identification of medical or vocational experts, if any, consulted in connection with the claim denial, without regard to whether the advice was relied upon in making the decision.

Liberty Mutual will make a full and fair review of your appeal and may require additional documents as it deems necessary in making such a review. A final decision on review will be made within a reasonable period of time but not later than 45 days following receipt of the written request for review unless Liberty Mutual determines that special circumstances require an extension. In such case, a written extension notice will be sent to you before the end of the initial 45-day period. The extension notice will indicate the special circumstances and the date by which they expect to render the appeal decision. The extension cannot exceed a period of 45 days from the end of the initial period.

The appeal time frames begin when an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date Liberty Mutual sends you the extension notice until you respond to the request for additional information are not counted as part of the appeal determination period.

Liberty Mutual's notice of denial will include:

- The specific reason or reasons for denial with reference to those Program provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim
- A statement describing any voluntary appeal procedures offered by the Program and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA
- If applicable, any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and a copy thereof will be provided free of charge upon request
- If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.

You and your Program may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Legal Actions

If you continue to be dissatisfied with Liberty Mutual's decision, you have the right to bring legal action against Liberty Mutual but you or your authorized representative cannot start any legal action:

- Until 60 days after proof of claim has been given, nor
- More than one year after the time proof of a claim is required (proof of a claim is required within 30 days from the date of disability onset)

You may also contact the California Department of Insurance (Department). The Department should only be contacted after you and Liberty Mutual have failed to produce a satisfactory solution to the problem.

Department of Insurance
Consumer Communications Bureau
300 South Spring Street – South Tower
Los Angeles, California 90013

Toll Free Hotline: 1-800-927-4357
Local Telephone Number: 213-897-5621
Fax: 213-736-2562
Office Hours: 8:00 a.m. – 5:00 p.m. PST

Conversion to an Individual Policy

The ***Disability Plan*** does not offer a conversion privilege.

Leaves of Absence

Information on leave practices is included in the Utility's Summary of Benefits Handbook for Management and Administrative & Technical Employees or by contacting the Utility's HR Service Center at 415-973-2363 or 1-800-788-2363.

Generally, the leave practices of PG&E Corporation and the Utility satisfy applicable state and federal requirements, and in some instances are more generous than applicable minimum regulatory requirements. When state or federal regulation applicable to a specific type of leave is more generous than the standard PG&E Corporation leave of absence practice, the state or federal requirements will be met.

A Leave of Absence requires approval and practices may vary by business entity. Please contact Human Resources for specific information on your eligibility for a leave of absence, the types of leaves available, the length of leaves, and the impact on benefits.

Family and Medical Leave Act (FMLA) Notice

A leave granted under any of the reasons provided by state and federal law (except as is otherwise required by the California Pregnancy Disability Act or other similar state laws) will be counted as family and medical leave and will be considered as part of the FMLA 12-workweek entitlement in a 12-month period.

The 12 month period is a 12 consecutive month period that begins on the first day of leave that qualifies under FMLA. A future 12 month period begins on the first day of leave that qualifies under FMLA after the previous 12-consecutive month period has ended. There is no carryover of unused leave from one 12-month period to the next 12-month period.

Benefits While Receiving STD or LTD Benefits

If, during your approved unpaid medical leave of absence, you are approved to receive benefits under the PG&E Corporation sponsored Short Term Disability (STD) or Long Term Disability (LTD) programs, PG&E Corporation will continue your medical (including prescription drug and mental health and substance abuse), dental, vision, EAP, and life insurance benefits during the entire period you receive STD or LTD benefits.

If you are not eligible to receive STD or LTD benefits and your approved leave of absence ends or your employment is terminated, your benefits will end.

Payment of Benefits

Benefits are paid to you. But, if a benefit is payable to your estate, or if you are not competent, Liberty Mutual has the right to pay up to $2,000 to any of your relatives or any other person whom they consider entitled by reason of having incurred expenses for your maintenance, medical attendance or burial. If Liberty Mutual, in good faith, pays the benefit as described in this paragraph, they will not have to pay the benefit again.

Rights of Recovery

If a benefit overpayment happens, you will be required to reimburse Liberty Mutual within 60 day of overpayment or they have the right to reduce future benefit payments until the overpayment has been repaid. They also have the right to recover overpayment directly from you or your estate.

Subrogation

When your injury appears to be someone else's fault, benefits will not be paid unless you or your legal representative agree:

1. To repay Liberty Mutual for benefits to the extent they are for losses for which compensation is paid to you by or on behalf of the person at fault;
2. To allow Liberty Mutual a lien on any compensation paid to you by or on behalf of the person at fault and to hold that compensation in trust; and
3. To execute and give Liberty Mutual any instruments needed to secure the rights under items 1 and 2 above.

In addition, when Liberty Mutual has paid benefits to you or on your behalf, they will be subrogated to all rights of recovery that you have against the person at fault. These subrogation rights will extend only to recovery of the amount Liberty Mutual has paid. You must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to Liberty Mutual.

Workers' Compensation

Workers' Compensation provides benefits for an employee's injury or illness that arises out of and occurs in the course of work. The Workers' Compensation program provides you with partial income replacement in the form of disability benefits and medical treatment. In the event of a work-related death, the program provides your dependents with death and burial benefits. Contact PG&E Corporation's Human Resources department for additional information about your Workers' Compensation program.

For The Record

In 1974, Congress passed the Employee Retirement Income Security Act (ERISA) to protect your interests and those of your beneficiaries under our employee benefit programs.

To comply with ERISA, this section presents administrative information about the programs as well as a statement of your rights under ERISA.

Plan Name and Number

PG&E Corporation Disability Plan – 503

Plan Sponsor

PG&E Corporation
One Market Street, Spear Tower, Suite #400
San Francisco, CA 94105

Employer Identification Number

The Internal Revenue Service has assigned PG&E Corporation the following identification number:

94-3234914

Plan Year

January 1 through December 31.

Participating Companies

The Participating Companies include any company that is directly owned by PG&E Corporation **and** whose participation has been approved by PG&E Corporation.

Funding

The ***Disability Plan*** is fully insured. Fully insured means PG&E Corporation holds a contract with the insurance carrier to provide benefits to program participants. The insurance carrier holds all responsibility and liability for determining what is and is not a benefit, processing claims, paying all expenses, and handling denials and appeals of denied benefits.

Source of Plan Contributions

PG&E Corporation pays all premium costs for ***the Disability Plan***.

Directory of Programs

The ***Disability Plan*** is covered by ERISA and is considered to be a welfare benefit program.

Directory of Programs					
Name of Program	**Policy or Contract No. /Service Area**	**Type of Program**	**Source of Contributions**	**Funding**	**Insurance Carrier or Administrator**
Short Term Disability Program	GT3-860-039115 (STD)/ National	Short-term term disability benefits	Employer paid	Fully Insured	Liberty Life Assurance Company of Boston 100 Liberty Way Dover, NH 03820 1-800-320-7585
Long Term Disability Program	GF3-860-039115 (LTD)/ National	Long-term disability benefits			

Plan Administrator

Employee Benefits Committee
PG&E Corporation
One Market Street, Spear Tower, Suite #400
San Francisco, CA 94105

415-267-7004

Agent for Legal Process

For disputes arising under the fully insured ***Disability Plan***, service of legal process may be made to the insurance carrier for the contract, at one of its local offices, or to the supervisory official of the Insurance Department in the state in which you reside. See "*Directory of Programs*" for information on which programs are fully insured.

Claims Administrators

The insurance company listed in the "*Directory of Programs*" administers claims for the ***Disability Plan***.

Administration

The Employee Benefits Committee (Committee) has been appointed as the Plan Administrator and is responsible for administering the ***Disability Plan*** described in this handbook. The Committee is appointed by, and serves at the pleasure of, the Board of Directors of the Plan Sponsor, its Executive Committee or its Nominating and Compensation Committee.

The Committee has discretionary authority to administer and interpret the Plan and programs, and to determine eligibility for benefits under the Plan and programs.

The Committee, Board of Directors, Executive Committee and the Nominating and Compensation Committee are empowered to amend or terminate the Plan and/or programs that make up the Plan, or any benefit under the Plan at any time.

Plan Documents

This ERISA-covered benefit program is based on a legal plan document. This document is a summary of some important features of each program. You may find full details in the official Plan Document. If Plan or program provisions outlined in this summary are inconsistent with the official plan documents, the wording of the official plan documents will always govern.

Changes

Plan and program benefits are available only while the Plan and programs are effective, and only pursuant to their terms. PG&E Corporation reserves the exclusive right to amend in writing, or end any employee benefit plan or program, at any time without prior notice to employees, dependents or beneficiaries. Employees, dependents, and beneficiaries have no vested rights in any plan or program described in this summary.

No Rights to Employment

The Plan and programs are not an employment contract. Nothing in the Plan or any of the programs that make up the Plan gives you a right to employment with PG&E Corporation or affects the right of PG&E Corporation to terminate your employment at any time, with or without cause.

Your Rights Under The Employee Retirement Income Security Act

Many of your benefits under the Plan and programs are covered by the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), including amendments to the Act. This federal law governs the operation of employee benefit plans and programs. It is important that you understand some of the provisions of this Act since they may affect you.

As a participant in the ***Disability Plan***, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Rights to Information

ERISA provides that all Plan participants are entitled to:

- Receive information about your Plan and program and benefits
  - Examine, free of charge, at the Plan Administrator's office, all documents governing the Plan or programs, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and programs, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan or program. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.