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Open Enrollment is November 8–21

Benefits 2014

Fellow PG&E Employees:

Open Enrollment is your opportunity to decide if your current medical coverage still fits the needs of you and your dependents. There's a lot of information in the news about other options for medical coverage as health care reform takes effect—but rest assured, you still have coverage through PG&E. We've included an update on health care reform and what it means for you inside.

I encourage you to review your medical plan options and take advantage of preventive care benefits that can help you and your family be well. Thank you for taking to heart your responsibility to make informed decisions about your health care for 2014.

John Simon
Senior Vice President, Human Resources

PG&E®

Summary of Material Modifications (October 2013)

This *Benefits 2014* brochure for Employees on Long-Term Disability is designed, in part, to make you aware of important changes that have been made to The Pacific Gas and Electric Company Health Care Plan for Active Employees (referred to as the Health Care Plan). Your 2014 enrollment materials are not an exhaustive explanation of the Health Care Plan. Additional information about the Health Care Plan is contained in the documents entitled *The Pacific Gas and Electric Company Health Care Plan for Active Employees* and the *Summary of Benefits Handbook*. The Summaries of Material Modifications (SMMs), including enrollment guides designated as SMMs and service provider agreements, collectively constitute the official plan document.

The Employee Benefit Committee of PG&E Corporation is the Plan Administrator of the Health Care Plan and has the discretionary authority to interpret and construe the terms of the official plan document, to resolve any conflicts or discrepancies between the documents that comprise the official plan document, and to establish rules that are necessary for the administration of the Health Care Plan.

Unless otherwise noted, references to PG&E in this booklet and in other enrollment materials mean Pacific Gas and Electric Company. Pacific Gas and Electric Company, PG&E Corporation and their affiliates are referred to collectively as "Participating Employers."

Pacific Gas and Electric Company has the right to amend or terminate the Health Care Plan at any time and for any reason, subject to notice provisions if such notice is required under applicable collective bargaining agreements. Generally, an amendment to or termination of the Health Care Plan will apply prospectively and will affect your rights and obligations under the Health Care Plan prospectively.

Grandfathered Health Plan Notice

The Anthem and Kaiser EPO benefit options available to employees in 2014 are "grandfathered" benefit options under the Patient Protection and Affordable Care Act of 2010 (PPACA). They are the only grandfathered benefit plans that are available under the Health Care Plan for Active Employees.

As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that already was in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the PPACA that apply to other plans—for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the PPACA, such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to lose grandfathered status can be directed to the plan administrator: Pacific Gas and Electric Company Plan Administrator, Benefits Department, 1850 Gateway Boulevard, 7th Floor, Concord, CA 94520. Or, you may contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing the protections that apply to grandfathered health plans.

NO QUESTIONS? NO NEED TO CALL

You do not need to call the HR Service Center if:

- **You have no questions about your benefits or coverage**
- **You're making no changes to your benefits**

The HR Service Center will be handling a high volume of calls during Open Enrollment. If you do have questions, please submit them via email, if possible: **hrbenefitsquestions@exchange.pge.com**

Please allow three full business days for a response. Additional contact information is listed on the back cover.

Medicare Coverage

If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, please see the Medicare Part D notice included in the 2014 *Legal Information* booklet that was mailed to you in September. If you need a copy of this notice, contact the HR Service Center.

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WELCOME

What's New for 2014?

There are just a few changes to PG&E-sponsored benefits for 2014. Here's a quick look at what's new.

Medical Page 7	**NEW BENEFIT: Medically necessary hearing aids covered.** All plans will cover medically necessary hearing aids and related exams, fittings, adjustments and repairs starting January 1, 2014: • **All Anthem plans and the Kaiser EPO** will cover 80 percent of the allowable cost for medically necessary hearing aids and related expenses. These plans will cover one hearing aid per ear every three years, and they'll automatically process your claims. • **The Kaiser Senior Advantage Plan** will pay 100 percent up to a flat dollar allowance of $1,000 or 80 percent of the total cost—whichever is greater—for one medically necessary hearing aid per ear and related expenses every three years.
	Special process for Kaiser Senior Advantage hearing aid claims. If you're enrolled in the Kaiser Senior Advantage plan, you may need to file claims for your medically necessary hearing aids and related expenses. Here's how your hearing aid benefit will work: **1.** Kaiser Senior Advantage will automatically pay 100 percent up to the flat dollar allowance for medically necessary hearing aids and related expenses. You need to exhaust this flat dollar allowance first. **2.** If Kaiser's $1,000 allowance doesn't cover the total cost, then you'll need to pay the difference. **3.** In addition, if Kaiser's $1,000 allowance doesn't cover at least 80 percent of the total cost of the hearing aid, you can file a claim for additional reimbursement with the administrator that processes the hearing aid benefit—called Your Spending Account (YSA). You'll need to submit your Explanation of Benefits (EOB) statement from Kaiser along with the total bill. If Kaiser Senior Advantage says your hearing aid was not medically necessary, then YSA won't pay anything. The minimum you can get as a total benefit is 80 percent of the cost. This includes your Kaiser Senior Advantage allowance plus any reimbursement from YSA. To request a YSA claim form for a medically necessary hearing aid purchased in 2014, call YSA at **1-800-964-9902**. Representatives are available Monday through Friday, 5 a.m. to 5 p.m. Pacific Time. You can also submit your claim online at **www.yourspendingaccount.com/pge**. Your payment amount will be displayed online once it's been approved and processed.

continued

DO YOU HAVE A NEW ADDRESS OR PHONE NUMBER?

Make sure your home address is correct because the availability of medical plans is based on where you live. If you've moved or you have a new phone number, please contact the HR Service Center to update your information.

See the back cover for the HR Service Center's contact information.

ENROLLING CHILDREN UP TO AGE 26

You can enroll children up to age 26 for medical coverage who are not eligible for coverage under an employer-sponsored health plan. If you have questions, contact the HR Service Center.

ROLLOVER HEALTH ACCOUNT CREDITS

If you were enrolled in the Health Account Plan (HAP) before you became disabled, you can keep any leftover Health Account credits if you go on Long-Term Disability and are enrolled in a PG&E medical plan.

You also get to keep your leftover Health Account credits if you're:

- Enrolled in the HAP, whether as an active employee or through COBRA
- Eligible for PG&E retiree medical coverage (even if you don't enroll when you retire)

Medical continued	**HSA Medical Plan going away—and HSA closed to new contributions.** The Health Savings Account (HSA) Medical Plan for non-Medicare employees on Long-Term Disability (LTD) will no longer be available. If you're currently enrolled in the HSA Medical Plan and you don't elect a different plan for 2014, you and your currently enrolled dependents will be automatically enrolled in the Anthem Network Access Plan (NAP) or Comprehensive Access Plan (CAP) for 2014, depending where you live. The Health Savings Account (HSA) will be closed to new contributions as of January 1, 2014, but you can still withdraw unused HSA balances for eligible health expenses. For 2014 and 2015, UMB Bank will continue to administer your account, and PG&E will continue to pay UMB Bank account administration fees. Starting in 2016, you'll need to pay the account administration fees to UMB Bank. To access your HSA balance, you can use the UMB Visa card you'll receive in January with your account balance preloaded on it, or you can submit claims for reimbursement to UMB Bank. You'll get a letter with more instructions about how to access your HSA account balance in January 2014.
Vision Page 13	**New Vision Service Plan (VSP) Choice Plan.** PG&E is replacing the current VSP Signature Plan with the VSP Choice Plan. There are no changes to your in-network benefits, and all VSP providers belong to both plans, so you'll be able to keep the same eye doctor. The new VSP Choice Plan has less of a discount on non-covered lens options and different reimbursement allowances for purchases from out-of-network providers.
Dental Page 14	**NEW BENEFIT: Dental implants covered.** Starting in 2014, you and your enrolled family members will have new coverage for dental implants. The Dental Plan will cover 85 percent of eligible costs for dental implants up to the annual $2,500 Dental Plan limit.

New Federal Tax Treatment of Benefits for Same-Sex Spouses

In light of the Supreme Court's 2013 ruling overturning Section 3 of the Defense of Marriage Act (DOMA), the Internal Revenue Service (IRS) has issued guidance addressing the federal tax treatment of benefits provided to same-sex spouses. Same-sex married couples will be treated as married for all federal tax purposes. This applies to any same-sex marriage legally entered into in one of the 50 states, the District of Columbia, a U.S. territory or a foreign country that allows same-sex marriage. The value of the health care coverage provided for a same-sex spouse or any enrolled children of a same-sex spouse will no longer be treated as income to you for federal tax purposes. You may wish to consult with your tax advisor to find out if you're eligible for any tax refunds relating to this change in tax treatment.

There are no changes to the federal tax treatment of benefits for registered domestic partners.

Health Care Reform Update

The Patient Protection and Affordable Care Act (PPACA) requires all individuals to have a basic level of health coverage starting January 1, 2014. A new health insurance marketplace (sometimes called the health exchange) is gearing up for January 1, and you may see a lot of information in the news about other options for health care coverage. In California, the state marketplace is called "Covered California."

The marketplace is generally intended for people who are uninsured or who buy insurance on their own. Everyone must have minimum essential coverage in place as of January 1, 2014, or potentially be subject to a tax penalty. That's the individual mandate. Whether you have employer-sponsored coverage, your own qualifying private health insurance or insurance coverage through the marketplace, it all works to fulfill the individual mandate.

MINIMUM ESSENTIAL COVERAGE REQUIRED FOR 2014

If you opt out of PG&E-sponsored medical coverage, make sure you have other medical coverage for 2014 that meets the federal government's minimum essential coverage requirements. If you don't, you could be subject to a tax penalty.

IF YOU'RE ON MEDICARE

If you're on Medicare, you'll still be able to enroll in a PG&E-sponsored medical plan. Your Medicare benefits aren't changing, and the marketplace doesn't require you to do anything:

- You won't lose Medicare coverage.
- You don't need a new Medicare card.
- You don't need to re-enroll in your Medicare Advantage or supplemental plan through the marketplace (these policies aren't sold through the marketplace).
- You don't have to buy supplemental insurance.
- You won't be fined if you don't buy coverage in the marketplace, as long as you have Medicare Part A.

WATCH OUT FOR SCAMS

Crooks are preying on the public's confusion over health care changes. Scams range from selling fake health insurance to asking for personal information to verify new Medicare cards (not required) or new national health care cards (there is no such thing).

Never give out personal or financial information to individuals or organizations you don't know or can't independently verify—and be cautious with cold calls or unsolicited emails or texts from people offering to help you understand the new health insurance marketplace. If someone calls out of the blue to verify your personal or financial information, hang up.

2

EXPLORE

Wellness

PG&E's wellness benefits work hand in hand with your medical coverage to help you maintain or improve your health:

Preventive Benefits	**Your medical, dental and vision plans offer checkups that can help keep you healthy for the long term:** • Annual physicals • Twice-a-year dental cleanings and checkups • Annual eye exams • Health screenings as recommended by your medical plan—such as OB/GYN exams, mammograms, prostate exams and colonoscopies
Free Flu Shots	**Anthem members:** You can get your seasonal flu shots at no cost at any of the retail pharmacies that sponsor flu shots in the Express Scripts retail pharmacy network. You'll need to have your Express Scripts Health ID card with you for claims processing. **Kaiser members:** You can get your free flu shot at your Kaiser clinic.
Tobacco Cessation Program	**When it comes to quitting smoking or chewing, each person's challenges and needs are unique.** Provant Health Solutions offers a free tobacco cessation program for you and your spouse or domestic partner. You'll get a five-week, phone-based program with one-on-one support with a certified tobacco cessation specialist. Nicotine replacement therapy is available to complement the program. To get started, call Provant at **1-866-271-8144**. Representatives are available Monday through Friday, 5 a.m. to 5 p.m. Pacific Time. You can start participating in the program anytime; you don't have to wait for 2014.
Employee Assistance Program	**Wellness isn't just about physical health; it's also about mental and emotional well-being.** The Employee Assistance Program (EAP) offers free, one-on-one, completely confidential support for a wide variety of life events and concerns. You and each of your family members are eligible for up to six sessions per six-month period to talk with a licensed EAP Counselor near your home about: • Stress management • Anxiety or depression • Family and relationship challenges • Alcohol and drug issues In addition, certified financial advisors, attorneys and work/life specialists are available for individual consultation at no cost to you: • Help with school issues, from kindergarten to college • Finding family-care resources (day care, elder care) • Tips on paying off your debt • Consultations on divorce, domestic violence and custody issues Visit **www.achievesolutions.net/pge** to explore all the ways the EAP can help. Call **1-888-445-4436** to speak to a licensed EAP Counselor, available 24 hours a day, seven days a week.

Medical

PG&E offers medical plan choices that include prescription drug, mental health and substance abuse benefits. Be sure to see the enclosed Enrollment Worksheet for the specific plans available to you and your costs for coverage, and the 2014 Medical Plan Comparison Charts for details about the benefits available under each plan.

The medical plan options available to you are based on:

- Whether you're eligible for Medicare—and
- Where you live

Some plans provide different benefits to their members after their members become eligible for Medicare. The plan names may even change. For example, Kaiser Permanente's corresponding Medicare Advantage HMO plan is called Senior Advantage.

1. **Be sure to review your 2014 Enrollment Worksheet** to see the specific plans available to you and your monthly contributions for each plan.
2. **Then, review the chart below** to determine the corresponding medical plan available to any dependents whose eligibility for Medicare is different than your own.

Medical Plan for Non-Medicare-Eligible Members*	Corresponding Plan for Medicare-Eligible Members*
Anthem Blue Cross Network Access Plan (NAP) or Comprehensive Access Plan (CAP)	Anthem Blue Cross Comprehensive Access Plan (CAP)
Kaiser Permanente EPO North and South	Kaiser Permanente Senior Advantage HMO North and South (Medicare Advantage HMO)

*All plans are subject to availability based on your home ZIP code.

ID CARDS

If you change medical plans or add dependents, you'll receive your new medical plan ID card:

- In January 2014 if you enroll during Open Enrollment
- Within 30 days of enrolling midyear

If you don't receive your new ID card on schedule, call your medical plan directly. If you need to see a doctor before your ID card arrives, use your confirmation statement as proof of coverage. If you're enrolled in an Anthem plan, you can print a copy of your ID card from the Anthem website.

For Anthem Blue Cross NAP and CAP Members

Free Generic Prescription Drugs Through Express Scripts Mail Order

More than 300 generic prescription drugs are available free of charge when you order them through the Express Scripts mail-order prescription drug program. Visit **www.medco.com/lowcostgenerics** to see a list of free generic mail-order drugs or call Express Scripts at **1-800-718-6590**.

If You Move Out of Your Plan's Service Area

You can switch to another PG&E-sponsored medical plan midyear only if you're enrolled in a medical plan with a defined service area and you move out of that plan's service area.

If any of your doctors or facilities withdraw from your medical plan during 2014, you will not be able to change medical plans.

Instead, you'll need to obtain services from a participating provider in your plan's network for the rest of the year. The withdrawal of a provider from your plan is not an eligible change-in-status event. For more information about changing coverage midyear, please see your copy of the *Summary of Benefits Handbook*.

Non-Medicare Medical Plan Options

The availability of medical plans is based on your home ZIP code. Non-Medicare-eligible dependents of Medicare-eligible employees will be enrolled in the non-Medicare plan that corresponds to the employee's Medicare plan, as described on page 7. Prescription drug coverage is included in all of the medical plans PG&E sponsors.

Non-Medicare Plans	Overview For benefit details, see the Medical Plan Comparison Charts in your enrollment packet	Cost for Care In addition to your contributions for coverage
Network Access Plan (NAP)*	This Preferred Provider Organization (PPO) plan gives you the flexibility to choose nationwide network or non-network providers.	• Annual deductible • Lower out-of-pocket costs when you use network providers
Comprehensive Access Plan (CAP)*	This out-of-area plan is for people who live outside the NAP's service area. This plan lets you use any licensed provider.	• Annual deductible • You may be able to lower your costs by using network providers
Kaiser Permanente EPO	This plan covers most services in full, but you must use Kaiser doctors and facilities to receive coverage.	• No deductible • You pay a copayment for office visits and other services • No charge for many services, such as hospital stays

*Under the NAP and CAP, Anthem Blue Cross administers medical benefits; ValueOptions administers mental health and substance abuse benefits; and Express Scripts administers prescription drug benefits.

KAISER EPO MEMBERS

Are you and your spouse both enrolled in the Kaiser EPO and another Kaiser plan? Remember—the Kaiser EPO won't coordinate benefits with other Kaiser plans.

If you have other, non-PG&E coverage with Kaiser, you won't receive a benefit from that plan.

EXAMPLE:

If your wife has a Kaiser plan through her non-PG&E employer and you're enrolled both as a dependent in her plan—and as an employee in the PG&E-sponsored Kaiser EPO—you won't receive any benefits from your wife's Kaiser plan. That's because the PG&E-sponsored Kaiser EPO will pay your benefits, since you're enrolled as an employee, not as a dependent.

Medicare Medical Plan Options

IMPORTANT:

Do not enroll in any Medicare Advantage plan or Medicare Part D Prescription Drug Plan that is not sponsored by PG&E. If you do so, your PG&E-sponsored medical and prescription drug benefits will be terminated.

As a Medicare-eligible participant, (under age 65 and on Medicare due to disability, or age 65 or older), you have a choice of the Comprehensive Access Plan (CAP) or the Kaiser Permanente Senior Advantage HMO (a Medicare Advantage HMO). To enroll in the Kaiser plan, you must live in a ZIP code served by Kaiser.

Under the CAP, Medicare processes your claims first, except for most prescription drug claims, which will be processed first by Express Scripts. For eligible medical expenses, the CAP provides secondary coverage—in other words, it processes your medical claims after Medicare processes your claims:

- Medicare Parts A and B are considered primary medical coverage.
- The CAP provides secondary medical coverage.
- The CAP provides primary prescription drug coverage through Express Scripts for most prescription drugs. Medicare provides primary coverage for Medicare Part B drugs, such as diabetic and transplant drugs.

The Kaiser Permanente Senior Advantage HMO coordinates its benefits with Medicare so you typically don't have to file claims. Special rules apply; please see page 11 for details.

Medicare Plans	Overview For benefit details, see the Medical Plan Comparison Charts in your enrollment packet	Notes
Comprehensive Access Plan (CAP)*	The CAP offers coverage from any licensed physician or hospital. There is no network of providers and you don't have to choose a primary care physician. **Prescription drug coverage** under the CAP is administered by Express Scripts. There is no direct coordination of benefits with Medicare on prescription drugs except for some drugs covered by Medicare Part B. See the Medical Plan Comparison Charts for details.	**The CAP pays only the difference necessary** to make your total reimbursement (Medicare's payment + CAP's payment) equal to the amount a non-Medicare member would receive. You still may be required to pay part of the claim.

*Under the CAP, Anthem Blue Cross administers medical benefits; ValueOptions administers mental health and substance abuse benefits; and Express Scripts administers prescription drug benefits.

Medicare Plans	Overview For benefit details, see the Medical Plan Comparison Charts in your enrollment packet	Notes
Kaiser Permanente Senior Advantage HMO (North and South) *A Medicare Advantage HMO*	To receive benefits, you must use Kaiser doctors and hospitals, except for medical emergencies. **Kaiser requires that you assign or "give away" your Medicare benefits to Kaiser.** By doing so, you no longer can use your Medicare benefits outside of Kaiser. **Kaiser prescription drug coverage:** When you enroll in the Kaiser Senior Advantage HMO, you'll be enrolled automatically in Kaiser's Part D prescription drug plan. Kaiser's prescription drug benefits are better than the standard Medicare prescription drug benefits, without deductibles or gaps in coverage. There is no direct coordination of benefits with Medicare on prescription drugs except for some drugs covered by Medicare Part B. See the Medical Plan Comparison Charts for details.	**Special enrollment rules:** You and your Medicare-eligible dependents must be enrolled in Medicare Parts A and B and you must sign a Medicare Advantage HMO Enrollment form. This form authorizes assignment of your Medicare benefits (Parts A and B) to the HMO and acknowledges your understanding that you will be enrolled in a Medicare Part D prescription drug plan through the HMO. When you enroll, the HR Service Center will send you the appropriate form to complete and return. If you don't receive the form within two weeks, please call the HR Service Center to inquire about the status of the form. **If you and your dependents are not enrolled in Medicare Parts A and B**, or you do not agree to complete the Medicare Advantage HMO Enrollment form, you won't be able to join the Kaiser Senior Advantage HMO. Instead, you'll be enrolled in the CAP, and you'll be responsible for the cost of coverage for that plan.

IMPORTANT:

Switching from the Kaiser Senior Advantage HMO to the CAP

The **Kaiser Permanente Senior Advantage Plan** is a Medicare Advantage HMO. If you're currently enrolled in this plan, you assigned your Medicare benefits to Kaiser—in other words, you gave up control of your Medicare benefits, so you can't use them outside of Kaiser.

If you want to switch from Kaiser Senior Advantage to the CAP, you'll need to complete a **Medicare Advantage HMO disenrollment form** to get back full use of your Medicare benefits. Follow these steps:

1. Elect the CAP during Open Enrollment.
2. As soon as you've made your election, contact the HR Service Center and ask them to mail you the **Medicare Advantage HMO disenrollment form**. You need to complete this form to regain control of your Medicare benefits. Otherwise, you can't use your Medicare benefits with the CAP.
3. Complete the disenrollment form and mail it back to the HR Service Center so they receive it no later than **November 29, 2013. This is important.** If the HR Service Center doesn't get your completed form on time, then you could have unpaid claims under the CAP—and you'll be responsible for paying those claims.

Note: If you don't receive your disenrollment form within two weeks of your request, call the HR Service Center and ask them to send you another form immediately (contact information is on the back cover).

You Must Enroll In Medicare When Eligible

It's important that you and your dependents are enrolled in Medicare Parts A and B as soon as you or your dependents become eligible for Medicare. To receive full benefits under PG&E's medical plans, you need to be covered by both Parts A and B.

If you've been receiving Social Security disability for 24 months, you may be eligible to enroll in Medicare Parts A and B. If you have ALS or end-stage renal disease, or if you'll be experiencing a kidney transplant, you do not have to wait 24 months. Please contact your Social Security office immediately.

Upon proof of enrollment in Part B, PG&E will reimburse the standard Part B premium for you and any eligible disabled Medicare-covered dependents, until you or your eligible Medicare-covered dependents reach age 65. See "Part B Premium Reimbursement Credits" for details.

If you do not retain both Medicare Parts A and B coverage for yourself and your Medicare-eligible dependents, your PG&E-sponsored medical plan will not pay the charges that would otherwise have been covered by Medicare, and you will not be eligible to enroll in the Kaiser Permanente Senior Advantage HMO. In addition, you will lose your Part B reimbursement from PG&E and you will have to pay Medicare a penalty to regain Part B coverage.

If you're under age 65 and you believe you or any of your dependents qualify for Social Security due to a disability, please contact Allsup, Inc., at **1-888-339-0743**. PG&E has contracted with Allsup, Inc., to provide Social Security enrollment assistance at no cost to potentially qualified disabled employees on LTD or their disabled dependents.

Part B Premium Reimbursement Credits

Once you or your disabled dependent are enrolled in Medicare Parts A and B, you're eligible to receive reimbursement from PG&E for the standard monthly Part B premiums you or your eligible Medicare-covered dependents pay to the Social Security Administration. To qualify for and initiate reimbursement from PG&E, you or your dependents must provide a copy of your Medicare card to the HR Service Center as soon as possible after enrolling. Upon receipt of the card, PG&E will begin reimbursing the Medicare Part B premium via a credit in your monthly LTD check. PG&E will not issue reimbursements on a retroactive basis, so it's important to promptly send PG&E a copy of your Medicare card when you first obtain Part B coverage.

The maximum number of reimbursements a family can receive for disabled members is three.

Vision

Administered by Vision Service Plan (VSP)

Under the VSP Choice Plan, you can use any licensed vision provider you choose, but you'll pay less when you use a VSP provider. If you use a non-VSP provider, you have to pay your bill in full, and VSP will reimburse you based on a schedule of benefits.

Vision Benefits

Choice of Doctor	Any; for maximum benefits, use a VSP doctor
Copayments with VSP Doctor	• $10/exam • $25/materials (lenses and frames)*
Benefits with VSP Doctor	• Vision exams—every 12 months • Eyeglass lenses—every 12 months • Frames—covered up to $150 every 24 months • Elective contact lenses—covered up to $150 every 12 months (you'll be eligible for a frames allowance 12 months after you get contact lenses) • Visually necessary contact lenses—covered in full when obtained from a participating doctor and only with prior authorization from VSP for medically necessary conditions • Ultraviolet lenses—covered at 100% after copayment • Photochromic lenses—covered at 100% after copayment • Lasik—covered up to $250 per eye (lifetime limit)
Non-Covered Lens Options	• 20% off unlimited additional pairs of prescription glasses and non-prescription sunglasses

*You're responsible for charges that exceed the plan's allowable expenses—and for the cost of cosmetic extras not covered by the plan, like blended, tinted or oversized lenses.

MORE INFORMATION

- **For information about your costs for Vision Plan coverage, see your 2014 Enrollment Worksheet.**
- **For a list of VSP providers, call VSP or visit www.vsp.com. When you make an appointment, be sure to identify yourself as a VSP member.**

Dental

Administered by Delta Dental

MORE INFORMATION

- For information about your costs for Dental Plan coverage, see your 2014 Enrollment Worksheet.
- For a list of Delta Dental PPO or Premier dentists, call Delta Dental or visit **www.deltadentalins.com/PG&E**.

You can save money on dental services by using a Delta Dental PPO Network dentist. You choose which type of dentist to use whenever you need dental care.

Type of Dentist	Your Deductible and Costs
Delta Dental PPO Dentist	The deductible and costs of dental services generally are lower with PPO dentists.
Delta Dental Premier Dentist	If you use a Delta Dental Premier Network dentist who does not also participate in the PPO network, the higher Premier deductible will apply. The maximum total deductible you'll pay per person in a calendar year is $50 because you won't be required to pay two separate deductibles for using both a PPO dentist and a non-PPO dentist.
Non-Participating Dentist	The higher Premier deductible will apply and non-participating dentists can charge fees that exceed Delta Dental's allowed rates—and you pay the difference.

Dental Benefits

PROVISIONS	DENTAL PLAN
Choice of Dentist	Any; for maximum benefits, use a PPO or Premier Dentist
Annual Deductible	Required for all covered services except diagnostic and preventive care. You pay only one deductible depending on the type of provider you use. **Delta Dental PPO Network** • $25/person; no more than $75/family • Applies if you use only PPO dentists **Delta Dental Premier Network or Non-Participating Dentist** • $50/person and $150/family • Applies if you use a Premier Network or Non-Participating dentist—even if you only use them once and you use PPO dentists every other time
Diagnostic and Preventive Care	No deductible You're responsible for 15% of covered charges for preventive care: • 2 exams/year • 2 cleanings/year • Fluoride treatments • Space maintainers • Full-mouth X-rays and Panorex films once every five years • Bitewing X-rays twice/year for dependents up to age 18; once/year for adults ages 18 and older

Basic Care	Deductible required
	You're responsible for 15% of covered charges for basic care:
	• Fillings
	• Oral surgery
	• Root canals
	• Extractions
	• Treatment of the gums (periodontia)
	• Sealants for eligible dependents under age 16
	  • Permanent first molars through age 8
	  • Second molars through age 15

Major Care	Deductible required You're responsible for 15% of covered charges for major care: • Crowns • Jackets • Inlays • Onlays • **NEW:** Implants • Cast restorations • Bridges
Annual Maximum Benefit	$2,500/person (excludes orthodontia)
Orthodontia	50% up to a lifetime maximum benefit of $2,000/person

Note: All benefits are subject to Delta Dental's usual, customary and reasonable allowances.

Life Insurance

Administered by MetLife

As an employee on LTD, you can't request life insurance coverage changes, but you can access MetLife's *MyBenefits* website to check your current coverage details.

To register for *MyBenefits*, go to **https://mybenefits.metlife.com/pg&e**. Once you're registered, you can:

- View and print a copy of your life insurance certificate by selecting "Forms" in the Tools & Resources box
- Check your current coverage and cost
- Name, change or review your beneficiaries

For help registering, call MetLife or visit the MetLife website.

What You Need to Do Now

As an employee on LTD, you can enroll:

- **Online through *PG&E@Work For Me* via the company intranet or over the Internet.** You can quickly access your benefit options and see your confirmation statement immediately after you've enrolled.
- **By calling the HR Service Center.** Representatives are available Monday–Friday, 7:30 a.m.–5 p.m. Pacific Time.

If you have Internet access, please enroll online. Call volumes are high during Open Enrollment. If you can enroll online, it allows us to serve others who need help.

Enrolling Online During Open Enrollment

To access *PG&E@Work For Me* on the company intranet (also applies to employees logging on through Citrix or VPN):

- Choose *PG&E@Work For Me* from the company intranet home page, under "Tools."
- Choose the Open Enrollment tab.

To access *PG&E@Work For Me* on the Internet from any computer with Internet Explorer (versions 5.0–8.0):

- Go to **https://myportal.pge.com**. If you're logging on for the first time, click the Help Guides link at the bottom of the page and follow the instructions to access the system.
- Choose the Open Enrollment tab.

(see next page)

QUESTIONS?

If you have questions about Open Enrollment or your benefits, contact the HR Service Center:

- Email **hrbenefitsquestions@exchange.pge.com**
- Call **415-973-4357** or **1-800-788-2363**

Representatives are available Monday–Friday, 7:30 a.m.–5 p.m. Pacific Time.

Call volumes are high during Open Enrollment and you may experience delays, so please be patient.

If you don't need assistance, there is no need to call; simply follow the instructions in your enrollment materials.

ENROLLING OR MAKING CHANGES TO YOUR BENEFITS

Annual Open Enrollment is your opportunity to make changes to your benefit coverage. You also get to enroll or make changes when you experience an eligible change-in-status event such as marriage or divorce. You have 31 days to make any allowable midyear changes to your benefits (180 days for the birth or adoption of a child—60 days if you're enrolled in Kaiser Senior Advantage).

For details on allowable changes, see your copy of the *Summary of Benefits Handbook*.

Then, follow these steps:

Review your dependents	Make any necessary changes to your dependent information. Have the following information on hand if you want to make a change: • Full name, birth date, gender, Social Security number, relationship (for example, spouse, child, registered domestic partner), Medicare Claim Number and effective date for any Medicare-eligible dependents (you can find this on your dependent's Medicare card). Please contact the HR Service Center if you want to add a registered domestic partner or a registered domestic partner's child to your plan, or if you want to add or drop a Medicare-eligible dependent.
Confirm your home address and phone number	Make sure your home address is correct because the availability of some medical plans is based on where you live. If you've moved or you have a new phone number, please email the HR Service Center to update your information: **hrbenefitsquestions@exchange.pge.com** Additional contact information is listed on the back cover.
Enroll	Enroll in the available benefit plan options that best fit your needs and the needs of your family.
Review your confirmation statement	Verify that the options you selected and the dependents you enrolled are shown on your confirmation statement. • You can access your confirmation statement through *PG&E@Work For Me* anytime after you enroll. • PG&E also will mail a confirmation statement to your home address or mailing address of record. For Open Enrollment changes, you'll receive your statement in December. For all other midyear enrollments, you'll receive your statement within 10 business days after enrolling. If any of your information appears to be incorrect, call the HR Service Center. Calls must be received within 10 business days of the date you receive your confirmation statement for a midyear change-in-status event or by the last business day of the year for Open Enrollment. All Open Enrollment changes must be made in the current plan year. **After December 31, 2013, you cannot make changes for 2014**, even if you want to make a change because of an error on your confirmation statement.
Print your confirmation statement	Keep a copy of your statement for future reference.

Technical Problems?

For help with technical questions about enrolling online, please contact PG&E's Technology Service Center (TSC). Representatives are available 24 hours a day, seven days a week.

- **Utility employees:** Call **415-973-9000** or **1-800-223-9007**
- **PG&E Corporation employees:** Call the Help Desk at **415-267-7025**

If You Don't Enroll During Open Enrollment

If you're currently enrolled in PG&E-sponsored health care coverage and you take no action, you'll automatically have the following coverage for 2014:

Medical *Not Eligible for Medicare*	**If you have the HSA Medical Plan**, you and your currently enrolled non-Medicare dependents will be automatically enrolled in an Anthem plan for 2014: • You'll get the Anthem NAP if you live within the NAP's service area. • You'll get the Anthem CAP if you live outside the NAP's service area. **If you have any other plan through Anthem or Kaiser**, you and your currently enrolled dependents will keep the same medical coverage you have now.
Medical *Eligible for Medicare*	You and your currently enrolled dependents will keep the same medical coverage you have now.
Dental	You and your currently enrolled dependents will keep the same dental coverage you have now.
Vision	You and your currently enrolled dependents will keep the same vision coverage you have now.
You'll be responsible for making any required contributions for coverage, as listed on your 2014 Enrollment Worksheet.	

If you're not currently enrolled in PG&E-sponsored health care coverage and you take no action, you'll have no coverage for 2014.

Minimum Essential Coverage Required for 2014

If you opt out of PG&E-sponsored medical coverage, make sure you have other medical coverage for 2014 that meets the federal government's minimum essential coverage requirements. If you don't, you could be subject to a tax penalty.

If you're currently enrolled in a PG&E-sponsored medical plan and you want to waive medical coverage for 2014, you'll need to elect that option during Open Enrollment.

IF YOU WERE ENROLLED IN THE HAP

If you were enrolled in the Anthem or Kaiser Health Account Plan (HAP) when you went on Long-Term Disability (LTD), on the first of the following month you'll automatically be enrolled in the available medical plan with the same administrator you had with the HAP (Anthem or Kaiser) unless you elect a different plan during Open Enrollment. You'll automatically get:

- The Anthem NAP or CAP if you were enrolled in the Anthem HAP
- The Kaiser EPO or Senior Advantage HMO if you were enrolled in the Kaiser HAP

For details about available plans, see page 7.

In addition, if you still had a balance in your Health Account when you went on LTD, you'll be able to continue to use the account to reimburse yourself for eligible expenses.

5

REMEMBER

Details About Your Coverage

There are a lot of details to remember about your coverage. Here are some of the most important points you need to be aware of.

You can enroll children up to age 26.

You can enroll children up to age 26 for medical coverage who are not eligible for coverage under an employer-sponsored health plan. If you have questions, email or call the HR Service Center.

You pay a steep penalty if you enroll ineligible dependents.

It's your responsibility to make sure your enrolled dependents are eligible. You must drop dependents from coverage within 31 days of the date they become ineligible for coverage. If you cover ineligible dependents, you'll be required to pay the company an amount equal to the cost of coverage for the period of time during which an ineligible dependent is enrolled, up to a maximum of two years of coverage—and you may be subject to termination of employment.

To drop ineligible dependents, email or call the HR Service Center.

The HR Service Center needs your dependents' correct Social Security numbers.

Please note that federal law (Medicare Secondary Payer Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (42.U.S.C.1395y(b)(7)&(b)(8)) requires the company to have Social Security numbers (SSNs) on file for many individuals enrolled in a PG&E-sponsored medical plan. This includes, among others, individuals age 45 or older as well as certain categories of individuals younger than age 45. By enrolling your eligible dependents in PG&E-sponsored health care plans, you agree to provide their SSNs. **If you fail to do so, your enrolled dependent(s) will be terminated from medical coverage.**

If your dependent's correct SSN is missing, you need to call the HR Service Center at **415-973-4357** or **1-800-788-2363**, and provide the SSN in order to continue medical coverage for that dependent. **In this situation, you need to call because we don't want you sending any SSNs over email for security reasons**.

HR SERVICE CENTER CONTACT INFORMATION

- Email **hrbenefitsquestions@exchange.pge.com**
- Call **415-973-4357** or **1-800-788-2363**

  Representatives are available Monday–Friday, 7:30 a.m.–5 p.m. Pacific Time.

Is your dependent child disabled?

If you have a disabled dependent under age 26 who is currently enrolled in a PG&E-sponsored medical plan, you'll need to get your child medically certified as disabled before he or she reaches age 26 to continue medical coverage from age 26 onward. You'll need to get the certification directly from your medical plan. This is the only way your disabled child can stay enrolled as your dependent in a PG&E-sponsored medical plan from age 26 onward.

If you don't get the medical certification before your child turns 26, then he or she will no longer be eligible for PG&E-sponsored coverage—and must be dropped from coverage by the first of the month following the month in which he or she turns 26. You also may have to periodically attest to ongoing eligibility based on disability, after the initial certification.

You can't cover disabled dependents age 26 or older if they:

- Were not already enrolled in a PG&E-sponsored plan when they turned 26—and
- Were not medically certified as disabled by a PG&E-sponsored medical plan when they turned 26.

You have to meet both conditions to continue covering disabled dependents from age 26 onward.

ELIGIBILITY INFORMATION

For details about eligibility, see your copy of the *Summary of Benefits Handbook*.

Member Services Information

PLAN AND CONTACT INFORMATION		
MEDICAL	**CONTACT**	**GROUP NUMBER**
Anthem Blue Cross-Administered Plans: **Network Access Plan (NAP)** **Comprehensive Access Plan (CAP)** Representatives are available Monday–Friday, 7 a.m.–8 p.m. Pacific Time	**1-800-964-0530** **www.anthem.com/ca/pge**	PZG170157
Kaiser Permanente EPO (North and South) Representatives are available: • Monday–Friday, 7 a.m.–7 p.m. Pacific Time • Saturday and Sunday, 7 a.m.–3 p.m. Pacific Time	NORTH: **1-800-663-1771** SOUTH: **1-800-533-1833** **www.my.kp.org/ca/pge**	**North:** 603702 **South:** 231142
Kaiser Permanente Senior Advantage (North and South) Representatives are available Monday–Friday, 8 a.m.–5 p.m. Pacific Time	**1-800-443-0815** **www.my.kp.org/ca/pge**	**North:** 28 **South:** 107932
Hearing Aid Reimbursement for Kaiser Senior Advantage (North and South) Contact Your Spending Account (YSA) Representatives are available Monday–Friday, 5 a.m.–5 p.m. Pacific Time	**1-800-964-9902** **www.yourspendingaccount.com/pge**	N/A
PRESCRIPTION DRUG	**CONTACT**	**GROUP NUMBER**
Prescription Drug Plan Administered by Express Scripts For NAP and CAP Representatives are available 24/7; closed Thanksgiving and Christmas	**1-800-718-6590** **www.express-scripts.com**	PGE0000
Prescription drug benefits are included in the Kaiser Permanente plans	N/A	N/A
MENTAL HEALTH AND SUBSTANCE ABUSE	**CONTACT**	**GROUP NUMBER**
Mental Health and Substance Abuse (MHSA) Program Administered by ValueOptions For Anthem and Kaiser plans Representatives are available 24/7	**1-800-562-3588** **www.valueoptions.com**	N/A
VISION	**CONTACT**	**GROUP NUMBER**
Vision Plan Administered by Vision Service Plan (VSP) Representatives are available: • Monday–Friday, 5 a.m.–8 p.m. Pacific Time • Saturday, 6 a.m.–5 p.m. Pacific Time	**1-800-877-7195** **www.vsp.com**	**Management and A&T employees:** 401601–Div 52, Class 10 **Union-represented employees:** 401601–Div 46, Class 3

PLAN AND CONTACT INFORMATION

DENTAL	CONTACT	GROUP NUMBER
Dental Plan Administered by Delta Dental Representatives are available Monday–Friday, 5 a.m.–5 p.m. Pacific Time	**1-888-217-5323** **www.deltadentalins.com/PG&E**	**Management and A&T employees (Utility):** 1515-0133 **Management and A&T employees (Corporation):** 1515-0233 **IBEW- and SEIU-represented employees:** 1515-0111 **ESC-represented employees:** 1515-0116
OTHER BENEFITS	**CONTACT**	**GROUP NUMBER**
COBRA Administered by Ceridian Representatives are available Monday–Friday, 5 a.m.–5 p.m. Pacific Time	**1-800-877-7994** **www.ceridian-benefits.com**	N/A
Employee Assistance Program (EAP) Administered by ValueOptions Representatives are available 24/7	**1-888-445-4436** **www.achievesolutions.net/pge**	N/A
Tobacco Cessation Program Administered by Provant Health Solutions Representatives are available Monday–Friday, 5 a.m.–5 p.m. Pacific Time	**1-866-271-8144**	N/A
Health Savings Account Administered by UMB Bank Representatives are available: • Monday–Friday, 5 a.m.–5:30 p.m. Pacific Time • Saturday, 6 a.m.–3 p.m. Pacific Time	**1-866-520-4HSA (4472)**	N/A
Life Insurance Administered by MetLife Representatives are available Monday–Friday, 5 a.m–8 p.m. Pacific Time	**1-888-878-8490** **https://mybenefits.metlife.com/pg&e**	**All employees:** 74300
Will Preparation Services Administered by Hyatt Legal Plans Representatives are available Monday–Friday, 5 a.m.–4 p.m. Pacific Time	**1-800-821-6400**	**All employees:** 74300
Allsup, Inc. Social Security Advocacy: Help enrolling in Medicare for potentially eligible disabled retirees and dependents Representatives are available Monday–Friday, 6 a.m.–3 p.m. Pacific Time	**1-888-339-0743**	N/A

PG&E Benefits Information and References

PG&E HR Service Center *For benefit and enrollment questions* Representatives are available Monday–Friday, 7:30 a.m.–5 p.m. Pacific Time	**hrbenefitsquestions@exchange.pge.com** 415-973-4357 or 1-800-788-2363
***PG&E@Work For Me* on the Internet**	**https://myportal.pge.com**
HR Intranet Site	PG&E@Work > Human Resources http://pgeweb/hr/pages/default.aspx
PG&E Technology Service Center (TSC) *For technical questions* Representatives are available 24/7	Utility employees: 415-973-9000 or 1-800-223-9007 PG&E Corporation employees: 415-267-7025
PG&E's *Summary of Benefits Handbook*	Go to *PG&E@Work For Me* **> Open Enrollment > Related Links**. Contact the HR Service Center to request a copy free of charge
IRS Publications	**www.irs.gov** 1-800-829-3676
Social Security Administration	1-800-772-1213
Medicare	**www.medicare.gov** 1-800-MEDICARE (1-800-633-4227)

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