Pacific Gas and Electric Company®

2005

Flex Benefits

Enrollment Guide

FLEX BENEFITS

Contents

SUMMARY OF MATERIAL MODIFICATIONS

October 2004

Take Charge of Your Health

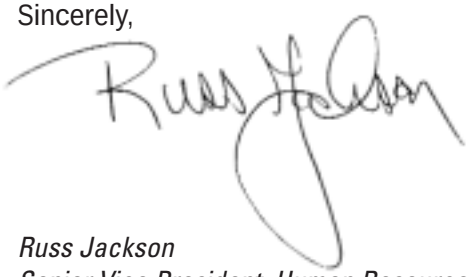
This guide is an overview of benefits. Complete details regarding benefit coverage are in the plan documents, contracts, and administrative policies available through the HR Service Center or through individual plan providers. Please note that this information does not replace all the documents governing the benefit plans, which will govern in case of any inconsistency. The Plan Administrator of each plan has the discretionary authority to interpret the provisions of the applicable plan. Pacific Gas & Electric Company reserves the right to amend, modify, or terminate any benefit plans. Although any change in a plan or the termination of a plan will not affect the benefits paid to plan members before the date the plan was changed or ended, such change may result in reduced levels of benefits or benefit coverage, or increased employee and/or retiree contributions, after the effective date of any such change.

A Message to PG&E Management and A&T Employees

On behalf of PG&E, I'm pleased to welcome you to the 2005 PG&E Flex Open Enrollment. As you read through this Guide, you will find detailed information on new plan features, including a new HMO option for 2005. We also provide tips on how you can save money on your health care-related expenses — including using the Reimbursement Accounts to lower your taxable income — as well as how you can take a more active role in making your health care decisions and choosing the best plan for your situation. Just look for the "Important Tip" boxes found throughout the Guide.

You have important decisions to make and a variety of options from which to choose. We're here to help, so if you have any questions about your benefit plan options or how they work, please feel free to contact the HR Service Center at **hrbenefitsquestions@pge.com** or by calling company line 223-2363, 415-973-2363, or 800-788-2363.

Sincerely,



Russ Jackson
Senior Vice President, Human Resources
PG&E Corporation and Pacific Gas and Electric Company




Health Care Costs Continue to Rise

As you know, health care costs have risen dramatically in the past decade, far outpacing other costs and rates of inflation. Among the many reasons for this trend are huge prescription drug cost increases, broader access to new (and often more expensive) treatments, an aging population that uses benefits more frequently, and consolidations among hospital facilities. For example, experts predict that the cost of inpatient hospital stays and prescription drugs will increase by 12 percent and 15 percent, respectively, in 2005.

All this, combined with the fact that a record 45 million Americans now do not have health care coverage, paints a pretty daunting picture.

Fortunately, as a PG&E employee, you can choose from a variety of medical coverage options for the one that best suits your individual needs. Along with this coverage, PG&E also provides you with several tools that can help you reduce your medical costs and get the most out of your medical plan.

Take Charge of Your Health Care Decisions

One of the most important things you can do as a health care consumer is to get actively involved in making your own health care decisions. Because your situation and needs may change from year to year, you should carefully review the medical plan options available to you to make sure you are selecting the best option each year.

Here are some questions you might want to ask yourself when looking at your medical plan options:

What are my estimated out-of-pocket costs for 2005?

You should consider deductibles and copayments for:

- Primary care doctor, specialist, in-patient and out-patient hospital and emergency room visits for you and your covered dependents. **Remember, the HMO options have no deductibles or hospital copayments.**
- Prescription drugs.
- Chiropractic, acupuncture, physical therapy or other non-routine care (some plans have limited or no coverage for these services).
- X-rays, lab services and durable medical equipment. Unlike the UnitedHealthcare-administered plans, there typically are no charges for these expenses with the HMOs.
- Outpatient physical therapy visits.
- Mental health and substance abuse treatment.

Am I taking advantage of available tax breaks?

Health care is expensive — as is dependent care. Fortunately, PG&E provides you with the Health Care and Dependent Care Reimbursement Accounts, which can be used to decrease your taxable income by the amount you pay for many common expenses, which in turn lowers your taxes and increases your spendable income. Please read more about the Reimbursement Accounts on pages 24 – 26 in this Guide.

Are my routine medications covered by the plan I'm considering?

If not, you may have to pay full cost. Call the plan's member services number to find out. Also, remember that generic drugs are usually significantly less expensive than brand-name equivalents.

What is the monthly premium cost for the plan I'm considering?

HMO premiums are generally less expensive than those for the plans administered by UnitedHealthcare. So, if your doctors participate in an HMO, it may be beneficial to enroll in that plan.

Does my doctor belong to the provider network for the plan I'm considering?

Call the medical plan's member services number to find out if your doctor is a participating physician, or call your doctor's office directly to find out which medical plans he or she contracts with.

The Comparison of Benefits charts found in this Guide show what the various medical plans cover for various types of services. By plotting out your anticipated needs throughout the year and then weighing them against your estimated monthly premium, copayment and deductible costs for each option, you will have a clearer picture of which plan may be best for you.

Also, be sure to look for the "Important Tip" boxes located throughout the Guide. They provide tips that can help you reduce your health care expenses, improve your health, or simply get the most out of your medical plan.

2005 Open Enrollment

This year's Open Enrollment period **begins on Monday, October 25, 2004, and ends on Friday, November 5, 2004.** You will be able to make your enrollment elections online or via the automated phone enrollment system. All of the information you need to enroll is being provided to you online. You may choose to print all or any part of this information at your own workstation.

Who Needs to Enroll?

If you plan to make **any** changes to your Flex Benefits coverage, contribute to either of the Reimbursement Accounts, or purchase FlexDays in 2005, you need to go through the enrollment process. Otherwise, you don't need to enroll. You will automatically receive the "Default Flex Coverage" described on page 7. Just be sure to review the following:

- Your current medical plan's availability and annual Flex cost for 2005, as shown on your Enrollment Worksheet;
- Your dependents' eligibility (see page 13);
- **What's New for 2005** (see pages 4 and 5); and
- Plan changes (indicated in bold on the Comparison of Benefits charts that begin on page 28).

Taking these easy steps will help ensure that your current Flex Benefits coverage is still the best coverage for you!

IMPORTANT

Open Enrollment begins on **Monday, October 25, 2004**, and ends on **Friday, November 5, 2004.**

What's NEW for 2005

Blue Shield of California HMO

To provide you with more medical plan options, PG&E will offer a new plan in 2005 — the Blue Shield of California Access+ HMO plan. The Blue Shield Access+ HMO will offer access to many employees and retirees who currently do not have access to an HMO. Be sure to check your personalized 2005 Enrollment Worksheet to see if you are eligible for the Blue Shield Access+ HMO plan.

Before enrolling in the plan, it's a good idea to confirm whether your doctors or other providers participate in Blue Shield's Access+ HMO network. For a directory of participating providers or other information about the new Blue Shield Access+ HMO, please call Blue Shield at 800-443-5005 or visit its website at **www.mylifepath.com**.

Deductibles for NAP and CAP Plans Changing

As announced last year, there will be a new deductible for the Network Access Plan (NAP) and the Comprehensive Access Plan (CAP) next year. Effective January 1, 2005, all in-network services received under the NAP plan through preferred providers and all services of any type provided under the CAP plan will be subject to an annual deductible of $100 per person, with a $300 maximum deductible per family. NAP services provided by non-preferred providers will continue to be subject to an annual deductible of $200 per person, with a $600 maximum deductible per family. All deductibles will apply towards your annual medical plan out-of-pocket maximums.

Please note that these deductibles only apply to covered medical services received through the NAP and CAP medical plans. They do not apply to outpatient prescription drug purchases obtained through the Prescription Drug Plan administered by Medco Health, nor do they apply to the mental health/chemical dependency services received through the plan administered by ValueOptions. Deductibles, copayments, and out-of-pocket maximums for these plans are separate.

Other HMO Changes

Some of the HMOs are making changes to their service territories and primary care provider networks in 2005. The information presented here is as up-to-date as possible as of the publication date of these materials. However, because of the ongoing nature of these changes, we recommend that you verify the service area and provider availability directly with each HMO. Phone numbers for each plan are listed on the outside back cover of this Guide.

New Rules for FlexDays

Beginning in 2005, you must use all of your vacation balance — including current, deferred, and service anniversary bonus vacation — prior to using any of your FlexDays. (Previously, Flex employees were only required to use current and service anniversary vacation – but not deferred vacation — prior to using FlexDays.) Please take this into consideration when deciding whether to purchase FlexDays for 2005. These changes are being made for purposes of legal compliance.

This new requirement does not apply to PG&E Corporation employees who are enrolled in the company's Flex Benefits Plan. Corporation employees will continue to follow the same FlexDay usage rules as in 2004. The cost of FlexDays for Corporation employees will be taken as a separate pre-tax deduction from their paycheck; Corporation employees cannot use FlexDollars to pay for FlexDays.

IMPORTANT TIP

Use your Health Care Reimbursement Account (HCRA) to lower the cost of your deductibles! Deductibles are an expense you can easily predict each year, so take advantage of the tax savings the HCRA can provide. You can also use the HCRA to help reduce the financial impact of copayments and other eligible health care expenses.

Medco By Mail – Same Rx Plan, New Name!

Medco Health, the company that manages prescription drug benefits for members enrolled in the UnitedHealthcare plans, is changing the name of its mail-order pharmacy service. Medco's "Home Delivery Pharmacy Service" will now be known as "Medco By Mail." Although the name of the mail-order service is changing, all of the plan benefits will remain the same, and you don't have to do anything differently to obtain prescriptions by mail.

Over the next few months, you may continue to see both the old name — Home Delivery Pharmacy Service — and the new name — Medco By Mail — until the transition has been completed.

New Magnetic ID Cards for UnitedHealthcare Members

All UnitedHealthcare members — both new and existing — will receive new membership identification cards in January 2005. The new cards will contain magnetic strips encoded with important information about your benefit coverage, such as copayment and coinsurance amounts, making it an easier, faster, and more accurate way for your health care providers to verify your membership and benefit details.

IMPORTANT

Be sure to check your *2005* Enrollment Worksheet to make sure your medical plan is still being offered where you live!

COBRA Changes

Cal-COBRA Update

- A recently enacted California bill — A.B. 245 — calls for the phasing out of the current California law commonly referred to as "Senior COBRA." Senior COBRA currently requires that extended COBRA continuation coverage be offered to certain HMO participants age 60 and older if their HMO coverage terminates. However, this special continuation coverage will no longer be offered to those participants who would otherwise have qualified for the coverage on or after January 1, 2005. Participants who are already receiving continuation coverage through Senior COBRA or those participants who qualified for Senior COBRA prior to January 1, 2005, will not be affected by this change.
- HMO members who exhaust their 18 months of federal COBRA coverage due to job termination or a reduction of work hours can extend COBRA coverage for another 18 months at 110%/150% of the normal premium. Members must contact their HMO for more information.
- Cal-COBRA now allows HMO members who exhaust their 36 months of COBRA continuation coverage to apply for a HIPAA Guaranteed Issue individual plan. Members should contact their HMO for more information.

COBRA Extensions Due to Medicare-Entitlement

Previously, when a former or reduced-hour employee became eligible for Medicare while covered under an 18-month COBRA extension, family members who were qualified beneficiaries were considered eligible for an extension of COBRA benefits. Due to a recent IRS ruling, these family members will no longer be offered COBRA extensions when the primary member becomes eligible for Medicare.

What You Need to Do for Open Enrollment

Five Easy Steps

1 Review your enrollment options by logging into the online enrollment system and opening your personalized 2005 Enrollment Worksheet. The worksheet shows the Flex Plan options available to you for next year and the 2005 Flex cost for each option.

2 Review your dependents' eligibility (see page 13 for eligibility rules). If you have a dependent who is no longer eligible for coverage, be sure to remove the dependent from your health care coverage. If your dependent is about to lose eligibility, be sure to contact the HR Service Center as well, so your dependent can receive a COBRA continuation coverage enrollment package.

3 Review the information in this Enrollment Guide, especially the **What's New for 2005** section and the **Comparison of Benefits Charts**.

IMPORTANT TIP

You can't participate in the Reimbursement Accounts for 2005 (HCRA and DCRA) unless you enroll, so think carefully before passing up on these valuable benefits!

4 Decide whether you need to enroll:

You **must enroll** if you want to:

- make plan changes [for example, if your current medical plan is no longer available in your area and you do not want to be automatically switched to the UnitedHealthcare plan (NAP or CAP) offered in your area];
- add or delete dependents;
- purchase FlexDays for 2005;

  or
- contribute to either of the Reimbursement Accounts — Health Care Reimbursement Account (HCRA) or Dependent Care Reimbursement Account (DCRA) — in 2005. Remember, any current HCRA or DCRA elections you have will not be carried over automatically into 2005, so think carefully before passing up these valuable benefits.

See **Before You Enroll** on page 10 for important things to consider prior to enrolling.

You **do not need to enroll** if:

- you want to keep all your current health care and life insurance benefit elections and you have verified that your current medical plan is still available in your area **OR** you want to keep all your current health care and life insurance benefit elections, but your current medical plan will no longer be offered in 2005 and you want to be automatically switched to the UnitedHealthcare plan (NAP or CAP) shown on your Enrollment Worksheet;
- you do not need to add or delete any dependents;
- you do not want to purchase FlexDays for 2005

  and
- you do not want to contribute to the HCRA or DCRA in 2005.

If you don't enroll, your current coverage will automatically default as described below under Default Flex Coverage.

5 To enroll, access the online enrollment system on the company intranet, or call the HR Service Center's automated phone system. See page 8 for more information on how to enroll. Then see **After You Enroll** on page 11 for additional information.

IMPORTANT

Once you enroll, the plan coverage you choose stays in effect for the entire calendar year. You may not make changes before the next Open Enrollment period unless you have an eligible change-in-status event before then (see page 15).

DEFAULT FLEX COVERAGE

- Your current 2004 medical coverage*, if your plan is still available in 2005 where you live. However, if your current medical plan is not available — for example, if you recently moved — you will be switched to the appropriate UnitedHealthcare plan (NAP or CAP) available in your ZIP Code.
- Your current 2004 dental coverage*
- Your current 2004 vision coverage*
- Your current 2004 life insurance coverage*
- No FlexDays
- No reimbursement account contributions
- Unused FlexDollars (if any) will be paid to you in cash as taxable income at the end of 2005.

** for you and your covered dependents, as listed on your 2005 Enrollment Worksheet.*

How to Enroll

Enroll using either of the following two methods during the Open Enrollment period:

The HR Intranet Website:
wwwhr

Enroll online by accessing the online enrollment system on the company's HR intranet website at **wwwhr/aboutyou** (or from PaGE ONE, select HR/About You). The HR website is available 24 hours every day on any computer which has access to the company intranet.

OR

The HR Service Center – Automated Phone System
Company Extension: 8-223-2363,
415-973-2363, or 800-788-2363

Enroll over the phone using the HR Service Center's automated phone system. The system is available 24 hours every day during Open Enrollment. If you need to speak to an HR Service Center representative, they are available by phone Monday through Friday from 7:30 a.m. until 5:30 p.m. Pacific Time.

Please use the company extension whenever possible. The "415" and "800" numbers are intended for employees to use only when a company number is not available to them. When an outside phone number is dialed from a company phone, the call ties up two phone lines (an external and an internal line).

Do not use portable, cellular or speaker phones to enroll. Also, be sure to go all the way through the call to confirm your selections. ***If you hang up before you confirm your selections, they will not be recorded.***

Whether you enroll online or over the phone, you will be sent a confirmation statement by company e-mail within 10 working days.

Any changes you make during Open Enrollment will be effective January 1, 2005. Changes cannot be made after the Open Enrollment period ends on Friday, November 5, 2004.

Enroll online or over the HR Service Center's automated phone system between Monday, October 25th and Friday, November 5th.

PLEASE READ!

By participating in any of the benefit plans sponsored by Pacific Gas and Electric Company, you are agreeing to:

- ✓ acknowledge that you are responsible for reading the 2005 Flex Enrollment Guide and reviewing your confirmation statement;
- ✓ authorize the company to release your Social Security number to third-party administrators and insurers, as required, for purposes of plan administration;
- ✓ authorize the company to deduct any required contributions from your paycheck;
- ✓ acknowledge that you will not be able to change medical plans mid-year if your physician, hospital, medical group, or Independent Physician Association (IPA) terminates its relationship with your medical plan during 2005;
- ✓ acknowledge that your current FlexDay and HCRA/DCRA elections cannot automatically roll forward into 2005 and that you must actively re-enroll to make new FlexDay and HCRA/DCRA elections for 2005;
- ✓ acknowledge that the company and the health plan administrators and insurers do not provide medical services or make treatment decisions; all treatment decisions are between you and your physician regardless of the benefits covered under the plan;
- ✓ follow the appeal process for your plan for any disputed benefit claims; and
- ✓ call the HR Service Center to report any ineligible dependents within 31 days of a dependent's loss of eligibility.

IMPORTANT

If you're on a leave during Open Enrollment, you'll be sent an Open Enrollment package at home. If your leave of absence extends into the next calendar year, your Open Enrollment elections will take effect on January 1. You will also be given the opportunity to re-enroll upon your return to work.

Before You Enroll

If You're Considering Changing Medical Plans…

Make sure your doctors participate in the network of the plan you're considering. If there are any prescription medications you take on a regular basis, you should make sure these drugs are covered by the new plan, since covered drugs vary from plan to plan. It's also a good idea to verify the coverage offered for specific types of services that you and your family tend to use regularly (for example, chiropractic services or urgent care visits).

Selecting Primary Care Physicians (PCPs)

You are not required to select a primary care physician (PCP) if you enroll in the NAP, CAP, or Basic Plan. However, all of the HMOs, except Kaiser, require that you and your covered dependents each select a PCP from the plan's network of doctors. When you first enroll in one of these plans, the HMO will automatically assign a primary care physician to you and any dependents you enroll. You may select a different PCP upon receipt of your membership ID card(s) in January. Call your plan as soon as possible after you receive your ID card(s) and request that your physician selection(s) be made retroactive to January 1, 2005. Each plan has its own policy and time frames for changing primary care physicians retroactively.

For a directory of primary care physicians, call the member services number of the medical plan you're considering, or visit its website. Phone numbers and website addresses for the medical plans are listed on the back cover of this booklet.

Adding Eligible Dependents

You must have the following information for each dependent you wish to add:

- Name
- Date of birth
- Sex
- Social Security number

Adding Domestic Partners

If you wish to add a domestic partner and/or a domestic partner's child(ren) to your plan, your partnership must be registered with the company or a governmental agency such as the City of Berkeley. In addition, there may be tax implications for you. For further information regarding domestic partner registration and benefits, call the HR Service Center to obtain a copy of *Your Guide to Domestic Partner Benefits at Pacific Gas and Electric Company*, or access the guide on the company intranet (from PaGE ONE, select Human Resources/Benefits/Domestic Partnerships).

It is important to keep this Enrollment Guide and refer to it throughout the year.

After You Enroll

Making Changes After Open Enrollment

After the annual Open Enrollment period ends, you cannot make any changes to your plan coverage until a subsequent Open Enrollment period, unless one of the following events occurs:

- You have an eligible change-in-status event (see page 15 for detailed information);
- You move out of your HMO's service territory; or
- You retire.

PLEASE NOTE! If any of your primary care physicians, specialists, medical groups, Independent Practice Associations (IPAs), hospitals, or other providers withdraws from your medical plan during the year, you will not be able to change medical plans mid-year. Instead, you will need to obtain services from a new provider within your plan's network for the remainder of the year. The withdrawal of a provider from your plan is not an eligible change-in-status event.

Confirmation Statements

- No matter which way you enroll (online or over the phone), you will receive your confirmation statement by e-mail within 10 working days.
- If you don't make any changes during Open Enrollment, you will receive a confirmation statement via company e-mail by December 31, 2004, verifying your Flex coverage for 2005.
- Employees who are not actively at work will receive their confirmation statement at home via U.S. mail.

Membership Identification Cards

If you don't receive your new ID card(s) by the end of January, call your medical plan directly. If you or a dependent needs to see a doctor before your identification card arrives, you can use your confirmation statement as proof of coverage. Members of the UnitedHealthcare plans also have the option of printing a copy of their ID card from UnitedHealthcare's website at **www.myuhc.com**.

IMPORTANT

Whether or not you make any changes to your coverage, you should review your confirmation statement carefully to ensure it is accurate. If there is an error, call the HR Service Center immediately at 223-2363, 415-973-2363, or 800-788-2363.

Other Important Information and Resources

Health Plans Cover Mastectomy-Related Services

Effective January 1, 1999, the Women's Health and Cancer Rights Act of 1998 mandated that group health plans covering mastectomies pay for certain reconstructive and related services following a mastectomy. For a member who is receiving benefits under a plan in connection with a mastectomy and who elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Coverage of breast reconstruction will be subject to the deductibles and coinsurance limitations consistent with those established for other benefits under your plan. For more information, contact your medical plan directly.

IMPORTANT TIP

UnitedHealthcare (UHC) medical plans offer a program called Cancer Resource Services (CRS) that helps covered members understand their cancer diagnosis and available treatment options, and provides access to premier cancer treatment centers to members with complex cancers. Call 866-936-6002 for additional information or help.

Employee Assistance Program (EAP)
888-445-4436

The Employee Assistance Program (EAP), provided to you by ValueOptions, is available 24 hours per day. This service, which is completely confidential and free of charge to you, can be a resource for such issues as:

- Marital and Family Problems
- Alcohol and/or Drug Problems
- Balancing Work and Family
- Depression
- Interpersonal Difficulties
- Stress/Anxiety
- Workplace Concerns
- Childcare/Eldercare Referrals
- Legal Concerns

You may also access the EAP online at: www.achievesolutions.net/pge

IMPORTANT TIP

Find Valuable Information About Your Benefits On the World Wide Web

Take advantage of our benefit plan vendors' Internet websites to access information about your personal benefit plans! Plan website addresses are listed on the outside back cover of this booklet. Some websites allow you to:

- ✓ Confirm eligibility for yourself and your dependents;
- ✓ Request new or replacement ID cards;
- ✓ Check the status of your claims online;
- ✓ Search for providers and/or switch primary care physicians;
- ✓ Check drug formulary information or order drug refills; and
- ✓ Learn about health and wellness topics, such as fitness and nutrition, pre-natal care, and disease management.

Eligibility

Who Is Eligible?

You are eligible to enroll in Flex if you are a Management or Administrative & Technical employee. You may also enroll your eligible dependents in the medical, dental and vision plans.

If you have any questions about whether or not a dependent is eligible for coverage, please call the HR Service Center or check your *Summary of Benefits Handbook*.

Eligible Dependents

Eligible dependents include:

- Your legally married spouse or registered domestic partner;
- Your unmarried, dependent children who are under age 19, including step-children, foster children, legally adopted children, and children for whom you have been permanently appointed legal guardianship by a court (does not include the legal wards of your spouse);
- The unmarried, dependent children of your registered domestic partner who are under age 19, including legally adopted children (a domestic partner's legal guardianship of a child is not included);
- Your unmarried, dependent children or those of your spouse/registered domestic partner who are age 19 through 23 and meet the IRS definition of an eligible dependent, whether or not you claim them as dependents on your income tax returns; or
- Your disabled dependent children or those of your spouse/registered domestic partner who are age 19 or older, who are certified as disabled by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) and who have been approved by the company for continued coverage (see **Disabled Dependents** in your *Summary of Benefits Handbook* for more information).

Note: If your spouse/registered domestic partner is also a company/PG&E Corporation employee or retiree, only one of you may enroll each child as a dependent in any one plan.

IMPORTANT

There are Penalties for Covering Ineligible Dependents

It is your responsibility to be sure all the dependents you enroll for coverage are eligible. Employees who cover ineligible dependents will be required to make restitution to the company for health care coverage up to $7,500 and may be subject to disciplinary action, up to and including discharge. If a dependent loses eligibility, he or she must be dropped within 31 days of loss of eligibility.

Dependent Certification

If you have a child who is between the ages of 19 and 23, please be aware that you may be asked to re-certify your child's status as an IRS-eligible dependent each year. **Dependents who lose eligibility during the year must be dropped within 31 days of the dependent's loss of eligibility.**

Domestic Partner Tax Certification

If you are covering a domestic partner and/or the children of a domestic partner, you must re-certify their tax dependency each year. If you don't receive a "Certification of Tax Dependency for Domestic Partnerships" form for the upcoming tax year, please call the HR Service Center to request a form.

National Medical Support Notices

If the company receives a court-ordered judgment or decree requiring you to cover an eligible dependent child, the child will be automatically enrolled in your health care plans, pursuant to the court order or judgment. Coverage for the child will be effective the first of the month following enrollment by the company, and your FlexDollar cost will be adjusted, if applicable.

Ineligible Dependents

Ineligible dependents include, but are not limited to:

- A divorced, legally separated, or common-law spouse, even if a court orders you to provide health care coverage;
- A domestic partner if your domestic partnership has not been formally registered with the appropriate government entity or the company's internal registry, or a former domestic partner;
- Parents, step-parents, parents-in-law, grandparents and step-grandparents;
- Former step-children or children of a former domestic partner, unless you have adopted them or have been appointed permanent legal guardianship by a court;
- Children age 19 through 23 who do not meet the current IRS definition of an eligible dependent;
- Children age 24 and over, unless they have been approved for continued coverage under the disabled dependent provision;
- Your disabled dependents if they have not been certified as disabled by a physician before they would otherwise cease to qualify as a dependent, and/or if they have not been approved by the company for continued coverage (see above);
- Married children or children who have entered the military (regardless of age or disability status);
- Children covered as dependents under the plan of another company/PG&E Corporation employee or retiree;
- Grandchildren, nieces, nephews, or other family members unless you have legally adopted them or have been appointed permanent legal guardianship by a court; or
- A family member or domestic partner who is a company/PG&E Corporation employee or retiree who has his or her own coverage through the company/PG&E Corporation.

IMPORTANT

You must drop ineligible dependents within 31 days of the dependent's loss of eligibility.

Change-In-Status Events

Once you enroll, the options you choose stay in effect for the entire calendar year. You may not make changes before the next open enrollment period unless:

- you have an eligible change-in-status event, or
- you retire.

IMPORTANT

Call the HR Service Center within 31 days of any eligible change-in-status event that may affect your benefits! Otherwise, you may not be able to add any dependents or change the amount you contribute to your Health Care Reimbursement Account or Dependent Care Reimbursement Account until the next Open Enrollment period.

You may only make changes to your coverage that are consistent with your change-in-status event. For example, if you get married you may add your new spouse and stepchildren (if any); however, you cannot change plans. Correspondingly, if you move out of your HMO's service territory, you may change plans, but you cannot add new dependents.

PLEASE NOTE! The withdrawal of a provider (e.g., doctor, medical group, hospital, etc.) from your plan's network is not an eligible change-in-status event. If any of your providers withdraw from your medical plan's network, you must obtain services from a different provider within your plan's network for the rest of the year. You cannot change medical plans mid-year as a result of a provider's withdrawal.

Eligible Change-in-Status Events:

- Marriage or the establishment of a registered domestic partnership
- Dissolution of marriage (including final divorce or annulment), legal separation, or termination of a domestic partnership. Please note that you cannot cover your ex-spouse on your company-sponsored health care plans even if a court orders you to provide coverage.
- The birth or adoption of a child, or your court-ordered appointment of legal guardianship for a child
- A change in your spouse's/registered domestic partner's or dependent's employment that results in a gain or loss of health care coverage
- A change to or from full-time or part-time employment by you or your spouse/registered domestic partner or dependents, if health plan eligibility is affected
- An unpaid leave of absence taken by you or your spouse/registered domestic partner that significantly impacts the cost of your benefits
- The death of your spouse/registered domestic partner or a dependent child
- Your dependent child reaching the plan's age limit, getting married, or entering the military
- Your dependent child regaining eligibility
- A change of caregivers, or a change in the cost for the services of a caregiver who is not a relative (for DCRA purposes only)
- A move out of your HMO's service territory (applies to change of medical plan only)

Move Out of HMO Service Area

If you move out of your HMO's service territory, you must call the HR Service Center within 31 days to select a new medical plan; otherwise, medical services you receive may not be covered. For more details, refer to your *Summary of Benefits Handbook*.

COBRA

When You, Your Spouse, or Your Other Dependents Lose Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows you or your covered dependents to continue participation in the company's group health plans beyond the normal period if coverage is lost due to a "qualifying event," as defined by COBRA. Obtaining coverage through COBRA is at your own cost and may continue for a period of up to either 18 or 36 months, depending on the event.

COBRA Qualifying Events

- Your termination of employment (for any reason other than gross misconduct)
- Loss of your company-sponsored group health coverage due to a reduction in work hours
- A change in your employment status from full-time to part-time
- Your death while covered as a plan participant
- Divorce or legal separation from your spouse
- Loss of eligibility by your dependent child

The company extends the same type of coverage rights to registered domestic partners and their children that it would extend to qualified beneficiaries under COBRA. Qualifying events to obtain this COBRA-like coverage are the same as those for spouses, including the dissolution of a registered domestic partnership.

IMPORTANT

To request continued coverage through COBRA, you must submit a "Notice of Qualifying Event" form to the HR Service Center within 60 days of loss of coverage.

Qualified dependents must be covered under your plan prior to the actual qualifying event. Dependents who are taken off your coverage before the event may have their right to continued health care coverage through COBRA jeopardized. You may be held financially responsible for providing health coverage for dependents dropped prematurely.

Dependents who are dropped during the Open Enrollment process may not qualify for continued coverage under COBRA, since these rights are only triggered by certain qualifying events and specific notification to the company. If you are dropping a dependent during the Open Enrollment period and are not sure whether or not your dependent is eligible for COBRA due to a qualifying event, please contact the HR Service Center. To request continued coverage through COBRA, you must submit a "Notice of Qualifying Event" form to the HR Service Center within 60 days of loss of coverage.

For complete information on COBRA eligibility and qualifying events, please refer to your *Summary of Benefits Handbook.*

If Your HMO Coverage Through COBRA Ends

For those qualified individuals who, on or after January 1, 2003, had a COBRA qualifying event that allowed for 18 months of continuation coverage under federal law, California law (Cal-COBRA) allows an additional 18 months of continuation coverage through your HMO upon the exhaustion of your federal COBRA coverage. Additionally, Cal-COBRA allows those who exhaust their 36 months of COBRA continuation coverage to apply for a HIPAA Guaranteed Issue individual plan. To obtain these extended coverages through Cal-COBRA, you must send a written request to your HMO within the HMO's specified time frame. For application materials, cost, or additional information, contact your HMO at least 60 days before your current COBRA coverage terminates.

Please note that Cal-COBRA's Senior COBRA continuation coverage is no longer available. Participants who are already receiving continuation coverage through Senior COBRA or those participants who qualified for Senior COBRA prior to January 1, 2005, will not be affected by this change.

FlexDollars

For the 2005 Flex Plan year, you will receive $1,699 in base FlexDollars plus an additional $250 in "FlexDay Dollars." You may also receive sick leave bonus FlexDollars if you used fewer than 32 hours of sick leave between October 1, 2003, and September 30, 2004. In addition, if eligible, you may receive transitional life insurance bonus FlexDollars. **(Note: PG&E Corporation employees are not eligible for the sick leave bonus or the transitional life insurance bonus.)**

Your 2005 Flex Enrollment Worksheet shows you the total amount of your FlexDollars for 2005. If you are a part-time employee, your FlexDollars will be prorated, as explained below.

Please remember that the Flex price for each option on your worksheet does not reflect the actual cost of coverage under the plan.

How are FlexDollars calculated for part-time employees?

If you were a part-time employee as of September 30, 2004, you will receive a percentage of the total FlexDollar amount, as indicated to the right, based on the number of straight-time hours you worked during the 12 months between October 1, 2003, and September 30, 2004.

If you change to full-time status between October 1, 2004, and the end of the year and you will remain full-time throughout 2005, call the HR Service Center to request full FlexDollars.

Hours worked 10/01/03 – 9/30/04	% of total FlexDollars you'll receive
0 – 415 hours	0%
416 – 831 hours	25%
832 – 1,247 hours	50%
1,248 – 1,663 hours	75%
1,664 – 2,080 hours	100%

How are bonus FlexDollars for the Sick Leave Usage Award calculated?

If you used 32 or fewer sick hours during the 12 months between October 1, 2003, and September 30, 2004, you'll receive additional FlexDollars, as indicated below.

Absences from work for less than four hours are not included in this Flex calculation.

The Flex Sick Leave Usage Award is prorated for part-time employees.

If you used:	You will receive additional FlexDollars equal to:
0-16 sick hours	0.45% of your annual pay (= 1.2 day's pay*)
Up to 24 sick hours	0.30% of your annual pay (= .8 day's pay*)
Up to 32 sick hours	0.15% of your annual pay (= .4 day's pay*)

** A day's pay is based on an eight-hour workday.*

Dental Coverage

Flex offers two levels of dental coverage: Dental 1 and Dental 2. Both plans are administered by Delta Dental and have different Flex prices. You may also decline dental coverage.

Remember, if you are now in Dental 1 and would like to change to Dental 2, you must choose the Dental 1 Transition Plan when you enroll. There's a one-year waiting period before you can receive Dental 2 benefits. During the waiting period, you pay the Dental 1 price and receive Dental 1 benefits. If you are now enrolled in the Transition Plan, you'll need to decide which plan you want for 2005 — Dental 1 or Dental 2. You may not enroll in the Transition Plan two years in a row.

If you are electing the default Flex coverage, your current 2004 dental plan, coverage level and covered dependents will remain the same for 2005. If you are currently enrolled in the Dental 1 Transition Plan and elect the default Flex coverage, you will default to the Dental 1 Plan.

You generally will save money if you use a dentist that participates in the Delta Dental network. Delta typically uses a higher reimbursement rate for participating dentists. If you choose to use a non-participating dentist, Delta may base its payment on a much lower reimbursement rate. You will be responsible for the difference between the fees actually submitted by your dentist and the potentially lower reimbursement rate as determined by Delta, in addition to your deductible and coinsurance.

If your dentist (whether a participating dentist or not) recommends extensive dental work, such as a crown, root canal, or bridge, ask your dentist to file a "predetermination" in advance of receiving the services. Delta will provide a predetermination claim notice to both you and your dentist. This notice will let you know if the procedure will be covered and, if so, will provide an estimate of how much your share of the claim will be.

If you would like a list of Delta's dentists, call Delta Dental at 888-217-5323 or check its website at **www.deltadentalca.org**.

The differences between Dental 1 and Dental 2 plan benefits are summarized on the following page.

IMPORTANT TIP

Remember, you can use the Health Care Reimbursement Account (HCRA) for anticipated dental expenses not covered by the plan, including deductibles, coinsurance, uncovered orthodontia costs, etc. Using the HCRA lowers your taxable income, which in turn lowers your tax bill for the year.

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

Plan Benefits		
Provision	**Dental 1/Dental 1 Transition Plan**	**Dental 2**
Choice of dentist	Any; for maximum benefits, use a Delta Dentist	Any; for maximum benefits, use a Delta Dentist
Annual deductible	$50/individual and $150/family for all covered services other than preventive & diagnostic	$50/individual and $150/family for all covered services
Diagnostic and preventive care	100% of eligible preventive care. Includes exams, X-rays, cleanings, fluoride treatments, and space maintainers. Also includes sealants for eligible dependents under age 14.	85% of eligible preventive care. Includes exams, X-rays, cleanings, fluoride treatments, and space maintainers.
Basic care	80% for fillings and root canals 50% for extractions, oral surgery, and treatment of the gums	85% of eligible basic care. Includes fillings, root canals, extractions, oral surgery, and treatment of the gums. Also includes sealants for eligible dependents under age 14.
Major care	50% of eligible major care. Includes crowns, jackets, inlays, onlays, cast restorations and bridges.	85% of eligible major care. Includes crowns, jackets, inlays, onlays, cast restorations and bridges.
Annual maximum benefit	$2,000 per individual (excludes orthodontia treatment)	$2,000 per individual (excludes orthodontia treatment)
Orthodontia	50% up to a $1,500 per individual lifetime benefit	50% up to a $1,500 per individual lifetime benefit

Vision Coverage

The vision plan is administered by Vision Service Plan (VSP). You have the option of using doctors in the VSP network or doctors of your own choice. You will generally pay less when you use a VSP provider. If you use a provider who is not in the VSP network, you pay the bill in full and VSP will reimburse you based on a schedule of benefits.

If you would like a list of VSP providers, call VSP at 800-877-7195 or check its website at **www.vsp.com**. When making an appointment, be sure to identify yourself as a VSP member.

Vision Plan Benefits	
Choice of doctor	Any; for maximum benefits, use a VSP member doctor
Copayments with VSP doctor (applicable to each covered person)	$10 vision exam $25 materials (lenses and frames)*
Plan benefits with VSP doctor	■ **Vision Exams** – Every 12 months ■ **Eyeglass Lenses** – Every 12 months ■ **Frames** – Every 24 months ■ **Contact Lenses, Elective & Visually Necessary** – Every 12 months in lieu of all other lens and frame benefits. When contact lenses are obtained, the covered person shall not be eligible for lenses again for 12 months and frames for 24 months. ● **Elective** – Covered up to $75 towards purchase and exam. If contact lenses are not obtained through prescribing doctor, member may be required to pay contact lens evaluation and fitting fee. ● **Visually Necessary** – Covered in full **only** with prior authorization from VSP and when obtained from a member doctor.

** Member is responsible for charges in excess of the Plan's allowable expenses in addition to the cost of cosmetic extras not covered by the plan, such as blended, tinted or oversized lenses, etc.*

IMPORTANT TIP

Remember, you can use the Health Care Reimbursement Account (HCRA) for anticipated vision care expenses not covered by the plan, including, copayments, costs for materials that exceed the plan's benefits, elective surgery, etc. Using the HCRA lowers your taxable income, which in turn lowers your tax bill for the year.

Life Insurance Coverage

Through the Flex Plan, you may select from six different levels of life insurance coverage. The Company provides the first $10,000 of coverage at no cost to you. Refer to your 2004 Flex Enrollment Worksheet for the Flex cost of additional coverage options.

Based On The Age You Turn On Your Birthday In 2005, your annual cost for each $1,000 in excess of $10,000 coverage is:		
Age	**Smoker**	**Non-Smoker**
Under 25	$ .56	$ .44
25-29	$ .68	$ .48
30-34	$ .91	$ .64
35-39	$ 1.02	$ .72
40-44	$ 1.25	$ 1.06
45-49	$ 2.02	$ 1.70
50-54	$ 3.12	$ 2.56
55-59	$ 5.26	$ 4.64
60-64	$ 7.94	$ 6.91
65-69	$14.40	$10.78
70 and older	$23.23	$16.13

The IRS requires that you pay taxes, called "imputed income taxes," on the value of your life insurance over $50,000. The amount on which you must pay taxes is automatically calculated at rates determined by the IRS and added to your gross income.

Increasing Your Life Insurance Coverage

If you choose Basic Life ($10,000) and you want to increase your coverage by one level in the future, you may choose Standard Life ($50,000) or Life 1 (coverage equal to one times your annual pay). If you choose Standard Life and you want to increase your coverage by one level in the future, your next higher level of coverage will be Life 2.

If you want to increase your life insurance coverage by two or more levels, you must provide proof of good health to Metropolitan Life Insurance Company. Metropolitan will send you a Statement of Health form at the end of Open Enrollment, which you will need to complete and return. Your 2005 Flex enrollment will be initially processed with a one-level increase only, pending approval by Metropolitan Life before any further level increase(s) in your 2005 life insurance amount will be made.

After Metropolitan Life receives complete information from you and your doctor, you will receive notification of its decision to approve or deny your request. If Metropolitan Life approves your request, your life insurance amount will be immediately increased to the higher level you requested, with coverage effective upon the date approved. Upon approval, your 2005 FlexDollars will be recalculated accordingly for the remaining months in the year to reflect the increased FlexDollar cost of the higher life insurance amount, and you will receive a revised confirmation statement to confirm the change. If your request is denied, your 2005 life insurance coverage will remain at the lower one-level increased amount for the rest of the year.

Note: If you increase your life insurance for 2005, you must physically be at work for at least one day in 2005 to be covered at the higher amount.

IMPORTANT

The Flex life insurance rate reduction that went into effect in 2004 will continue through December 31, 2005. This reduction is a result of demutualization proceeds paid to the company by Metropolitan Life Insurance Company when it became a publicly traded company. The proceeds paid to the company are being used to provide Flex employees with a 5.5% premium reduction for 2004 and 2005.

Get Help Preparing Your Will — For FREE!

Has preparing a will been on your back burner, but you never seem to get around to it? Well, help is here, and it's free! PG&E employees who have elected more than $10,000 of employee life insurance in 2005 may once again take advantage of this special program that provides free will preparation assistance.

The program, offered by Hyatt Legal Plans, a MetLife company, has been extended through December 31, 2007. Eligible employees and spouses/registered domestic partners may consult with one of the plan's 9,000 attorneys, nationwide, for assistance in preparing or updating their will, free of charge. (Note: this benefit does not cover preparation of living wills.)

Important Reasons to Have a Will:

- Allows you to protect your assets and preserve your family's financial future.
- Lets you select beneficiaries of your estate and direct how and when they will receive your assets.
- Lets you designate guardians for your minor children in the event of your death.
- Without a valid will, many decisions about asset distribution, estate management and care of minor children will be determined by state laws, rather than your personal wishes.

PLEASE NOTE! Having a will does not replace any designated beneficiary(ies) you have on file with PG&E for any of your company-provided benefits.

To use this program, simply contact Hyatt Legal Plans at 800-821-6400. Client Service Representatives are available Monday through Thursday from 5:00 a.m. to 4:00 p.m. and on Fridays from 5:00 a.m. to 3:00 p.m., Pacific Time. You will be asked to provide your PG&E life insurance Group Number (74301 for Management and A&T employees) and your Social Security number. Once your eligibility has been verified, the Hyatt Client Service Representative will provide you with a case number and help you locate a participating attorney in your area.

Don't be one of the approximately 70 percent of people who don't have a will. Call Hyatt Legal Plans today!

FlexDays

IMPORTANT

Through Open Enrollment, you may buy up to five extra vacation days, called FlexDays, each year. However, you must use all of your current year's vacation, deferred vacation, and any service anniversary vacation, before you can use your FlexDays.

You must use your 2005 FlexDays by December 31, 2005. To comply with this rule, you may sell unused FlexDays back to the Company by submitting an approved "Pay for Unused FlexDays" form (#62-3595) to the Payroll Department by the last business day in November. You will receive payment in December 2005. Any days not used or sold on time will be forfeited, regardless of the reason. Please note that for PG&E Corporation employees, unused FlexDays at year's end will automatically be cashed out in the January paycheck (second biweekly check for A&T employees).

New hires who purchase FlexDays may use their FlexDays prior to receiving their vacation allotment. However, once they become eligible for vacation, their current year's earned annual vacation days must be used before FlexDays. FlexDays may be taken in increments of one hour.

The Flex price for each FlexDay is based on your base salary for an eight-hour workday as of September 30, 2004.

To Buy:	You Pay:
One FlexDay	.3845% of annual base pay (one day's pay*)
Two FlexDays	.7690% of annual base pay (two days' pay*)
Three FlexDays	1.1535% of annual base pay (three days' pay*)
Four FlexDays	1.5380% of annual base pay (four days' pay*)
Five FlexDays	1.9225% of annual base pay (five days' pay*)

**A day's pay is based on an eight-hour workday.*

Unused FlexDollars

Any Unused FlexDollars will be paid to you in your December 2005 paycheck as taxable income. (NOTE: Administrative & Technical employees will receive any Unused FlexDollars in their second paycheck in December 2005.)

If you leave the Company before the end of the year, your Unused FlexDollar payout will be prorated based on your date of termination

Reimbursement Accounts

(Flexible Spending Accounts)

Among the many valuable benefits the company offers to you are **the Health Care Reimbursement Account (HCRA) and the Dependent Care Reimbursement Account (DCRA).** These reimbursement accounts — also referred to as Flexible Spending Accounts, or "FSAs" — offer you a way to save on taxes for certain out-of-pocket health care and dependent care expenses. The HCRA and DCRA are separate; you may sign up for either or both. Both accounts are administered by UnitedHealthcare.

You may contribute FlexDollars, pre-tax salary contributions, or a combination of both. The minimum contribution to each account is $50 per year. Any salary contributions you make will reduce your taxable income. (Note: FlexDollar contributions do not reduce your taxable income.) During the plan year, when you incur an eligible expense, you may pay the provider and then file a claim for reimbursement from your account — which reimburses you with pre-tax dollars. UnitedHealthcare members enrolled in the HCRA can elect to take advantage of the Automatic Reimbursement feature which automatically forwards claims for any out-of-pocket medical and/or Medco Health prescription drug plan expenses (copayments, coinsurance, deductibles, etc.) to UnitedHealthcare for reimbursement through your HCRA. In addition, all employees who elect to contribute to either the HCRA or DCRA may choose to have their reimbursement checks directly deposited to the banking institution of their choice.

If you do not use all of the funds in your reimbursement account(s) for the plan year, you will forfeit the remaining amount. Expenses must be incurred during the plan year in which you elect to contribute. You have until March 31 of the following year to submit claims for expenses incurred in the previous year.

If you want to begin participating in the HCRA or DCRA, or if you're currently participating in either type of account and want to continue contributing in 2005, you **must** enroll during Open Enrollment to indicate the *annual* amount you want to contribute.

> Your HCRA/DCRA elections for 2004 cannot be carried over automatically into 2005.

Health Care Reimbursement Account (HCRA)

Having an HCRA allows you to pay for certain out-of-pocket health care expenses (such as hearing aids, contact lens solution, or health plan deductibles and copayments) on a pre-tax basis. During Open Enrollment, you estimate what your total out-of-pocket expenses will be for the upcoming year for yourself and your IRS-eligible dependents — even if they are not enrolled in the company's health plans. You then authorize the company to deduct that amount (not to exceed $5,000) using FlexDollars and/or pre-tax deductions from your paycheck.

Be sure to estimate your potential health care expenses carefully, since unused HCRA contributions will be forfeited.

Eligible expenses are generally the same as those approved by the IRS for tax deduction purposes, **except for salary and/or FlexDollar contributions that you pay towards your health care premiums, which are not eligible for reimbursement through the HCRA.** For a list of what the IRS allows as eligible expenses, refer to IRS Publication 502, Medical and Dental Expenses, available directly from the IRS by calling 800-829-3676 or on the IRS Internet website at **www.irs.gov**. In addition, although the IRS does not allow over-the-counter or "OTC" (i.e, non-prescription) drug expenses for tax deduction purposes, some OTC drugs may be eligible for reimbursement through the HCRA. Please contact UnitedHealthcare for information on which OTC drugs may be eligible for reimbursement.

Mid-Year Changes in HCRA Contributions

You may increase or decrease your HCRA annual contribution goal during the year only if you have certain eligible change-in-status events and your change in contribution is consistent with the status change. For example, if you get divorced and you no longer expect to pay health care expenses for your former spouse, you may decrease your HCRA, but you cannot increase it. Please note that a change in the cost of your health insurance coverage does not constitute a valid reason to make a mid-year change in the amount you contribute.

If you begin contributing mid-year after an eligible change-in-status event, expenses incurred before you began contributing are not eligible for reimbursement.

IMPORTANT TIP

Some over-the-counter (OTC) drugs, like aspirin and cold medicine, are eligible for reimbursement through PG&E's Health Care Reimbursement Account (HCRA). Check with UnitedHealthcare in advance to verify if specific OTC drugs you purchase may be reimbursable and, if so, what documentation will be required.

Dependent Care Reimbursement Account (DCRA)

Both the DCRA and the Federal Dependent Care Income Tax Credit can lower your taxes, but in different ways. If you have more than one child, under certain circumstances you may use both methods. Otherwise, you may only use one of the two methods. Your tax advisor can help you decide how to maximize your tax savings. If you are married, both spouses must be actively at work or attending school (unless one of you is disabled) for a DCRA expense to be valid. If one spouse is at home (for example, on a maternity leave), expenses incurred for day care are not eligible for reimbursement. In addition, day care expenses must not exceed your salary or, if you are married, your spouse's salary. Refer to the *IRS Publication 503, Child and Dependent Care Expenses,* on the IRS website at **www.irs.gov**, or call the IRS at 800-829-3676 to obtain the publication.

Mid-Year Changes in DCRA Contributions

You may make a change in the annual amount you contribute only if you have an eligible change-in-status event (such as the birth or adoption of a child), and your change in contributions is consistent with the status change. You may also make a corresponding change to your DCRA if you replace one dependent care provider with another or if there is a change in the cost for the services of a caregiver who is not a relative. For example, if you want to change from using a day care center to employing an aunt to watch your child, an election change would be permitted even though the aunt is related to you. If, however, you decide to give your aunt a raise, you may not make a mid-year election change to reflect the raise. The IRS will not allow a mid-year change to your DCRA for a change in the fee charged by a relative.

If you begin contributing mid-year after an eligible change in status, expenses incurred before you began contributing are not eligible for reimbursement.

How Much Can You Contribute Each Year?

Reimbursement Account	Annual Contribution Amount
Health Care	$5,000 maximum per individual or married couple filing a joint tax return (married individuals filing separate income tax returns may each contribute up to $5,000).
Dependent Care	$5,000 maximum per individual or married couple filing a joint tax return (married individuals filing separate income tax returns may each contribute up to $2,500). Your annual contributions to the dependent care account cannot exceed your spouse's income. If your spouse is a full-time student or is mentally or physically disabled, he or she is considered to have an annual income of $2,400 if you have one eligible child or $4,800 if you have more than one child.

Comparison of Prescription Drug Benefits

For UnitedHealthcare Plans (Administered by Medco Health)

The following table summarizes the prescription drug benefits for members enrolled in the UnitedHealthcare plans. Plan benefits are administered by Medco Health. Please note that the Medco Health out-of-pocket maximum does not coordinate with the UnitedHealthcare out-of-pocket maximum.

For general information regarding the prescription drug coverage provided by each HMO, refer to **Outpatient Prescription Drugs** on the Comparison of Benefits charts that follow. For more specific information about an HMO's drug coverage, call the HMO's member services department directly or visit its website at the Internet address listed on the outside back cover.

Provisions	NAP, CAP, and Basic Plans
Retail Drug Purchases	First three 30-day supplies at a participating pharmacy: 85% for generics, 75% for brand names. Generic Incentive Provision applies (see below). Refills beyond 90 days and coverage at non-participating pharmacies: 80% for generics and 70% for brand names. Generic Incentive Provision applies (see below).
Home Delivery (Mail-Order) Purchases	90% for generic drugs and 80% for brand-name drugs. Generic Incentive Provision applies (see below).
Generic Incentive Provision	Member is responsible for paying the difference between the price of a generic drug and a brand-name drug, plus coinsurance, if purchasing a brand name-drug when a generic version is available. Please note that any generic-brand price differential you pay is a non-covered expense and, thus, does not count towards your annual out-of-pocket maximum (see below). Drugs that are listed on Medco Health's "Narrow Therapeutic List" will be excluded from this mandatory generic provision.
Deductible	No deductible
Annual Out-of-Pocket Maximum	$500 per person; $1,000 per family. Out-of-pocket maximum coordinates the retail drug benefit with the home delivery drug benefit, but does not coordinate with medical plan. Non-covered expenses, such as generic-brand price differentials, are not eligible expenses and, thus, will not be covered by the plan after your annual out-of-pocket maximum is met.
Lifetime Maximum	No lifetime maximum
Infertility, Sexual Dysfunction, Memory Enhancement and Contraceptive Drugs	50% for both retail and home delivery drugs, unless medically necessary. Medically necessary drugs are covered at standard reimbursement rates. Generic Incentive Provision applies (see above)

Comparison of Benefits Chart

Flex

This benefit chart is a summary only. Refer to your health plan's Evidence of Coverage (EOC) for details. The EOC is the binding document between the health plan and its members. In case of conflict between the benefit chart and the EOC, the EOC will prevail.

Provisions	Blue Shield Access+ HMO	Health Net
General	Members access the Blue Shield HMO network	Only providers affiliated with Health Net HMO
Hospital Stay	No charge	No charge; includes intensive and coronary care
Skilled Nursing Facility	No charge; 100-day limit	No charge; 100-day limit
Emergency Room Care	$25/visit for emergencies (waived if admitted). Member needs to contact PCP within 24 hours of service	$25/visit for emergencies (waived if admitted). Must notify Health Net within 48 hours.
Outpatient Hospital Care	$10/visit	$10/visit
Maternity Care	No charge	No charge
Well-Baby Care	$10/visit	$10/visit
Office Visits	Office visit – $10; $30 without referral (Access+ Specialist) – must be in the same Medical Group or IPA; Home visit – $10	Office visit – $10 Home visit – $10
Urgent Care Visits	$10/visit	$10/visit
Routine Physical Examinations	$10/visit according to health plan schedule	$10/visit for basic Periodic Health Evaluation
Immunizations and Injections	No charge	Included in office visit. **Injections related to infertility services covered at 50%.**
Eye Examinations	$10/visit for refraction	$10/visit
X-rays and Lab Tests	No charge	No charge
Pre-Admission Testing	No charge	No charge
Home Health Care	No charge	No charge
Hospice Care	No charge	**No charge**
Outpatient Physical Therapy	$10/visit; as long as continued treatment is medically necessary pursuant to the treatment plan	$10/visit; provided as long as significant improvement is expected
Outpatient Prescription Drugs	Retail drugs (up to 30-day supply): $5 copay for generic formulary, $15 copay for brand formulary, and $35 copay for non-formulary. Some drugs require preauthorization Mail-order drugs (through the plan): two times retail copay for up to a 90-day supply. No annual maximum; open formulary	Retail drugs (up to 30-day supply): $5 copay for **primarily** generic formulary, $15 copay for **primarily** brand formulary, and $35 copay for non-formulary. Some drugs require preauthorization. Mail-order drugs (through the plan) at two times retail copay for up to a 90-day supply. No annual maximum; open formulary
Mental Health*		
Inpatient Care	Severe mental illness (same as parity diagnosis): No charge; no day limit. Other mental illnesses: No charge for up to 30 days/calendar year for crisis intervention.	Severe mental illness (same as parity diagnosis): No charge; no day limit. Other mental illnesses: No charge for up to 30 days/calendar year for crisis intervention
Outpatient Care	Severe mental illness (same as parity diagnosis): $10/visit; no visit limit. Other mental illnesses: $20/visit; 20 visits per calendar year	Severe mental illness (same as parity diagnosis): $10/visit; no visit limit. Other mental illnesses: $20/visit; 20 visits per calendar year
Alcohol and Drug Care		
Inpatient Care	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions
Outpatient Care	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions
Durable Medical Equipment	No charge; preauthorization required. See plan EOC for limitations and exclusions.	No charge; preauthorization required. See plan EOC for limitations and exclusions.
Chiropractic Care	Not covered	Not covered
Acupuncture	Not covered	Not covered
Other Benefits	Infertility treatment – 50% of covered services, including drugs and laboratory. See plan EOC for detailed coverage.	Infertility treatment – 50% of covered services, including drugs and laboratory. See plan EOC for detailed coverage.

Coverage for mental health is provided through the HMO only, not ValueOptions

*Changes for 2005 are in **bold-faced** type*

Comparison of Benefits Chart

Flex

This benefit chart is a summary only. Refer to your health plan's Evidence of Coverage (EOC) for details. The EOC is the binding document between the health plan and its members. In case of conflict between the benefit chart and the EOC, the EOC will prevail.

Provisions	Kaiser Permanente North	Kaiser Permanente South
General	Services provided at Kaiser Permanente Hospitals and Offices by Kaiser Permanente doctors	Services provided at Kaiser Permanente Hospitals and Offices by Kaiser Permanente doctors
Hospital Stay	No charge; includes intensive and coronary care	No charge; includes intensive and coronary care
Skilled Nursing Facility	No charge to members in service area for up to 100 days per benefit period when prescribed by a plan physician. Not covered for members living outside of service area.	No charge to members in service area for up to 100 days per benefit period when prescribed by a plan physician. Not covered for members living outside of service area.
Emergency Room Care	$25/visit for emergencies (waived if admitted). Must notify Kaiser within 24 hours.	$25/visit for emergencies (waived if admitted). Must notify Kaiser within 24 hours.
Outpatient Hospital Care	$10 per procedure for outpatient surgery; $10/visit for all other outpatient services may apply	$10 per procedure for outpatient surgery. $10/visit for all other outpatient services may apply.
Maternity Care	No charge	No charge
Well-Baby Care	$10/visit	$10/visit
Office Visits	Office visit – $10 Home visit – No charge	Office visit – $10 Home visit – No charge
Urgent Care Visits	$10/visit	$10/visit
Routine Physical Examinations	$10/visit	$10/visit
Immunizations and Injections	$10/visit for immunizations & allergy testing if no office visit; $5/visit for allergy injections if no office visit	$10/visit for immunizations & allergy testing if no office visit; $5/visit for allergy injections if no office visit
Eye Examinations	$10/visit for screening/refraction; lenses and frames not covered	$10/visit for screening/refraction; lenses and frames not covered
X-rays and Lab Tests	No charge	No charge
Pre-Admission Testing	No charge	No charge
Home Health Care	No charge to members in service area when prescribed by a plan physician. Not covered for members living outside of service area.	No charge to members in service area when prescribed by a plan physician. Not covered for members living outside of service area.
Hospice Care	No charge to members in service area when prescribed by a plan physician. Not covered for members living outside of service area.	No charge to members in service area when prescribed by a plan physician. Not covered for members living outside of service area.
Outpatient Physical Therapy	$10/visit; therapy is given if in the judgment of a plan physician significant improvement is achievable	$10/visit; therapy is given if in the judgment of a plan physician significant improvement is achievable
Outpatient Prescription Drugs	$10 copay for up to 100-day supply when obtained at a plan pharmacy or through plan's mail-order; no annual maximum; closed formulary	$10 copay for up to 100-day supply when obtained at a plan pharmacy or through the plan's mail-order; no annual maximum; closed formulary
Mental Health*		
Inpatient Care	No charge for up to 30 days per calendar year; no day limit for mental health parity diagnoses	No charge for up to 30 days per calendar year; no day limit for mental health parity diagnoses
Outpatient Care	$10/visit (individual), $5/visit (group) for up to 20 visits per calendar year; no visit limit for mental health parity diagnoses	$10/visit (individual), $5/visit (group) for up to 20 visits per calendar year; no visit limit for mental health parity diagnoses
Alcohol and Drug Care		
Inpatient Care	No charge for detoxification. Also covered by separate Alcohol and Drug Care Program with referral by ValueOptions (inpatient only).	No charge for detoxification. Also covered by separate Alcohol and Drug Care Program with referral by ValueOptions (inpatient only).
Outpatient Care	$10/visit (individual); $5/visit (group)	$10/visit (individual); $5/visit (group)
Durable Medical Equipment	No charge to members in service area when prescribed by a plan physician. See plan EOC for limitations and exclusions. Not covered for members living outside of service area.	No charge to members in service area when prescribed by a plan physician. See plan EOC for limitations and exclusions. Not covered for members living outside of service area.
Chiropractic Care	Not covered	Not covered
Acupuncture	Not covered	Not covered
Other Benefits	Infertility treatment – 50% of covered services, including drugs and laboratory. See plan EOC for detailed coverage.	Infertility treatment – 50% of covered services, including drugs and laboratory. See plan EOC for detailed coverage.

Coverage for mental health is provided through the HMO only, not ValueOptions

Comparison of Benefits Chart

Flex

This benefit chart is a summary only. Refer to your health plan's Evidence of Coverage (EOC) for details. The EOC is the binding document between the health plan and its members. In case of conflict between the benefit chart and the EOC, the EOC will prevail.

Provisions	PacifiCare
General	Only providers affiliated with PacifiCare HMO
Hospital Stay	No charge for semi-private room; includes intensive and coronary care
Skilled Nursing Facility	No charge; 100 days per calendar year from first treatment, per disability
Emergency Room Care	$25/visit for emergencies (waived if admitted as an inpatient). Must notify PacifiCare within 24 hours.
Outpatient Hospital Care	$50/visit
Maternity Care	No charge
Well-Baby Care	$10/visit
Office Visits	Office visit – $10 Home visit – $10
Urgent Care Visits	$25/visit
Routine Physical Examinations	$10/visit
Immunizations and Injections	Included in office visit
Eye Examinations	$10 copay for vision screening/refractions; lenses and frames not covered
X-rays and Lab Tests	No charge
Pre-Admission Testing	No charge
Home Health Care	No charge, **up to 100 visits per calendar year**
Hospice Care	No charge up to 180 days per lifetime in a facility or on an outpatient basis
Outpatient Physical Therapy	$10/visit; unlimited visits
Outpatient Prescription Drugs	RETAIL (up to 30-day supply): $5 copay for generic formulary, $15 copay for brand formulary, and $35 copay for non-formulary; no annual maximum; open formulary. MAIL-ORDER (through the plan): two times retail copay for 90-day supply; no annual maximum; open formulary **$50 self-injectable medication copay for 30-day supply**
Mental Health*	
Inpatient Care	No charge up to 30 days per calendar year (unlimited days for parity diagnosis)
Outpatient Care	$20/visit up to 20 visits per calendar year for non-parity diagnoses. Severe mental illness (same as parity diagnosis): included with no visit limits for outpatient care at $10.
Alcohol and Drug Care	
Inpatient Care	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions
Outpatient Care	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions
Durable Medical Equipment	No charge; preauthorization required. See plan EOC for limitations and exclusions. **$5,000 annual maximum per calendar year.**
Chiropractic Care	Discounts available through "PERKS" program. Contact PacifiCare for details.
Acupuncture	Discounts available through "PERKS" program. Contact PacifiCare for details.
Other Benefits	Infertility Treatment – 50% of covered services, including drugs and laboratory. See plan EOC for detailed coverage.

Coverage for mental health is provided through the HMO only, not ValueOptions

*Changes for 2005 are in **bold-faced** type*

Comparison of Benefits Chart

Flex

The information in this chart is intended as a summary only. The applicable legal documents will govern actual benefits.

Provisions	Comprehensive Access Plan (CAP) Administered by UnitedHealthcare	Basic Plan Administered by UnitedHealthcare
General	May use provider of choice or network providers; **$100 upfront annual deductible per individual, up to family maximum of $300**; annual out-of-pocket maximum of $750 per individual, up to family maximum of $1,500 (includes deductible); no lifetime maximum *All plan benefits and out-of-pocket maximums are based on Eligible Expenses only.**	May use provider of choice; $250 upfront annual deductible per individual, up to family maximum of $750; $2,500 annual out-of-pocket maximum per individual, up to family maximum of $5,000 *All plan benefits and out-of-pocket maximums are based on Eligible Expenses only.**
Hospital Stay Skilled	100% after a $100 copayment; preauthorization required for non-emergency care, $300 penalty if not obtained; covers semi-private room (private if Medically Necessary); includes intensive care.	70% after deductible for semi-private room (private if Medically Necessary); includes intensive care.
Nursing Facility	90% for semi-private room after 3 days in hospital; preauthorization required, $300 penalty if not obtained.	70% after deductible only after 3 days in hospital; covers semi-private room.
Outpatient Hospital and Emergency Room Care	100% after $35 copay for medical emergency or outpatient surgery; waived if admitted.	70% after deductible
Maternity Care	Covered as any other condition. Preauthorization of delivery stays beyond 48 hours for normal delivery and 96 hours for cesarean section; $300 penalty if not obtained.	Covered as any other condition
Well-Baby Care	Covered as any other condition	Not covered
Office Visits	Primary care – 100% after $10 copay; specialist (including OB/GYN) – 100% after $20 copay	70% after deductible for office and home visits
Urgent Care Visits	Primary care – 100% after $10 copay; specialist (including OB/GYN) – 100% after $20 copay	70% after deductible
Routine Physical Examinations	Primary care – 100% after $10 copay; specialist – 100% after $20 copay; lab/X-ray covered separately	Not covered, except for Pap smears and mammogram test fees
Immunizations and Injections	95%	70% after deductible
Eye Examinations	Not covered	Not covered
X-rays and Lab Tests	90%	70% after deductible
Pre-Admission Testing	95%	**70% after deductible**
Home Health Care	90%; requires prior authorization, $300 penalty if not obtained.	100% after deductible; requires prior authorization.
Hospice Care	90%; requires prior authorization, $300 penalty if not obtained.	100% after deductible; requires prior authorization.
Outpatient Physical Therapy	80%	70% after deductible
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health. See page 27 for details.	Covered by separate prescription drug plan administered by Medco Health. See page 27 for details.
Mental Health Inpatient Care Outpatient Care	Covered by separate Mental Health Program ■ 100% with referral by ValueOptions; 50% without referral. ■ $15/visit with referral by ValueOptions, no charge for initial visit to psychiatrist (M.D.) for medication evaluation; 50% without referral, up to 30 visits per year.	Covered by separate Mental Health Program ■ 100% with referral by ValueOptions; 50% without referral. ■ $15/visit with referral by ValueOptions; no charge for initial visit to psychiatrist (M.D.) for medication evaluation; 50% without referral, up to 30 visits per year.
Inpatient and Outpatient Alcohol and Drug Care	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions
Durable Medical Equipment	80%; preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained.	70% after deductible
Chiropractic Care	80% for Medically Necessary care only; preauthorization by ASHN required after initial visit.	Medically necessary care only; 70% after deductible; maintenance not covered.
Acupuncture	80% for up to 20 visits per year from licensed acupuncturist or M.D.	Not covered
Other Benefits	Infertility – Paid according to type of benefit; $7,000 lifetime maximum. Balances from prior plans carry forward. Transplant Services – 100%, preauthorization and use of Designated United Resource Network Facility required.	Infertility – 70% after deductible; $7,000 lifetime maximum.

** "Eligible Expenses" are: (1) expenses for Covered Health Services that are covered by the plan; (2) those that UnitedHealthcare considers "Medically Necessary" for the diagnosis or treatment of an illness or injury; and (3) those that do not exceed the "Reasonable and Customary" rate as determined by UnitedHealthcare. Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call UnitedHealthcare Member Services.*

Comparison of Benefits Chart

Flex

The information in this chart is intended as a summary only. The applicable legal documents will govern actual benefits.

Provisions	Network Access Plan (NAP) Administered by UnitedHealthcare	
	Network	**Non-Network**
General	Care provided by network providers. **$100 upfront annual deductible per individual, up to family maximum of $300**; annual out-of-pocket maximum of $750 per individual, up to family maximum of $1,500 (includes deductible); no lifetime maximum on benefits.	Care provided by non-network providers. $200 upfront annual deductible per individual, up to family maximum of $600; annual out-of-pocket maximum of $1,000 per individual, up to family maximum of $2,000 (includes deductible); no lifetime maximum on benefits. *All plan benefits and out-of-pocket maximums are based on Eligible Expenses only.**
Hospital Stay	100% after $100 copay; preauthorization required for non-emergency care, $300 penalty if not obtained; covers semi-private room (private if Medically Necessary); includes intensive care.	70%; preauthorization required for non-emergency care, $300 penalty if not obtained; covers semi-private room (private if Medically Necessary); includes intensive care.
Skilled Nursing Facility	90% for semi-private room after 3 days in hospital; preauthorization required, $300 penalty if not obtained.	70% for semi-private room after 3 days in hospital; preauthorization required, $300 penalty if not obtained.
Outpatient Hospital and Emergency Room Care	100% after $35 copay for medical emergency or outpatient surgery; waived if admitted.	100% after $35 copay for medical emergency; 70% for outpatient surgery.
Maternity Care	Covered as any other condition. Preauthorization of delivery stays beyond 48 hours for normal delivery and 96 hours for cesarean section; $300 penalty if not obtained.	Covered as any other condition. Preauthorization of delivery stays beyond 48 hours for normal delivery and 96 hours for cesarean section; $300 penalty if not obtained.
Well-Baby Care	Covered as any other condition	Covered as any other condition
Office Visits	Primary care – 100% after $10 copay; Specialist (including OB/GYN) – 100% after $20 copay	70%
Urgent Care Visits	Primary care – 100% after $10 copay; Specialist (including OB/GYN) – 100% after $20 copay	70%
Routine Physical Examinations	Primary care – 100% after $10 copay; Specialist – 100% after $20 copay; lab/X-ray covered separately.	70%
Immunizations and Injections	95%	70%
Eye Examinations	Not covered	Not covered
X-rays and Lab Tests	90%	70%
Pre-Admission Testing	95%	70%
Home Health Care	90%; requires prior authorization, $300 penalty if not obtained.	70%; requires prior authorization, $300 penalty if not obtained.
Hospice Care	90%; requires prior authorization, $300 penalty if not obtained.	70%; requires prior authorization, $300 penalty if not obtained.
Outpatient Physical Therapy	80%	70%
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health. See page 27 for details.	Covered by separate drug plan administered by Medco Health. See page 27 for details.
Mental Health	Covered by separate Mental Health Program	Covered by separate Mental Health Program
Inpatient Care	■ 100% with referral by ValueOptions; 50% without referral	■ 100% with referral by ValueOptions; 50% without referral
Outpatient Care	■ $15/visit with referral by ValueOptions, no charge for initial visit to psychiatrist (M.D.) for medication evaluation; 50% without referral, up to 30 visits per year.	■ $15/visit with referral by ValueOptions; no charge for initial visit to psychiatrist (M.D) for medication evaluation; 50% without referral, up to 30 visits per year.
Inpatient and Outpatient Alcohol and Drug Care	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions
Durable Medical Equipment	80%; preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained.	70%; preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained.
Chiropractic Care	80% for care approved by ASHN using ASHN provider	70% for up to 15 visits for Medically Necessary care
Acupuncture	80% for up to 20 visits per year from licensed acupuncturist or M.D.	70% for up to 15 visits per year from licensed acupuncturist or M.D.
Other Benefits	Infertility – Paid according to type of benefit; $7,000 lifetime maximum. Balances from prior plans carry forward.	Infertility – Paid according to type of benefit; $7,000 lifetime maximum. Balances from prior plans carry forward.

** "Eligible Expenses" are: (1) expenses for Covered Health Services that are covered by the plan; (2) those that UnitedHealthcare considers "Medically Necessary" for the diagnosis or treatment of an illness or injury; and (3) those that do not exceed the "Reasonable and Customary" rate as determined by UnitedHealthcare. Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call UnitedHealthcare Member Services.*

HMO Availability Chart

This chart lists the HMO plans offered in selected counties in California. Plan availability is based on ZIP codes and may be limited in some counties. Please call each HMO directly if you would like to verify its availability in your ZIP code.

● = Coverage in Entire County ▲ = Coverage in Some Parts of County

County	Blue Shield Access+	Health Net	Kaiser North & South	PacifiCare
Alameda	●	●	●	●
Amador			▲	
Butte	●			
Colusa				
Contra Costa	●	●	●	●
El Dorado	▲	▲	▲	▲
Fresno	●	▲	▲	●
Glenn				
Humboldt				
Imperial			▲	▲
Kern	▲	▲	▲	●
Kings	●	●	▲	●
Lake				
Los Angeles	●	●	▲	▲
Madera	●	●	▲	▲
Marin	●	●	●	▲
Mariposa			▲	
Mendocino				
Merced	●	●		●
Monterey				
Napa		●	▲	
Nevada	▲	▲		▲
Orange	●	●	●	●
Placer	▲	▲	▲	▲
Plumas				
Riverside	●	▲	▲	▲
Sacramento	●	●	●	●
San Bernardino	▲	▲	▲	▲
San Diego	▲	●	▲	●
San Francisco	●	●	●	●
San Joaquin	●	●	●	●
San Luis Obispo	●			●
San Mateo	●	●	●	●
Santa Barbara	●	●		●
Santa Clara	●	●	▲	●
Santa Cruz	●	●		●
Sierra				
Solano	●	●	●	●
Sonoma	●	●	▲	●
Stanislaus	●	●	●	●
Sutter			▲	
Tehama				
Tulare	●	●	▲	●
Ventura	●	●	▲	●
Yolo	●	●	▲	●
Yuba			▲	

Pacific Gas and Electric Company®

Where to Get Help

Topic	Contact	Phone Number / Web Site
Questions About Enrollment or Benefits	PG&E HR Service Center	Co. Ext. 223-2363, 415-973-2363, or 800-788-2363
	E-Mail Address	HRBenefitsQuestions@pge.com
	HR Web Site	wwwhr
	or refer to your *Summary of Benefits Handbook*	
IRS Publications	IRS	800-829-3676 or www.irs.gov

Member Services Numbers

For information or provider directories, call the appropriate plan's number or visit its website.

Plan	Phone Number	Web Site
Blue Shield of California	800-443-5005	www.mylifepath.com
Dental Plan (Administered by Delta Dental)	888-217-5323	www.deltadentalca.org
Employee Assistance Program	888-445-4436	wwwhr/benefits
Health Net	800-522-0088	www.healthnet.com
Kaiser Permanente (North and South)	800-464-4000	my.kaiserpermanente.org/ca/pge
PacifiCare	800-624-8822	www.phs.com
PG&E Medical Plans (Administered by UnitedHealthcare) Network Access Plan (NAP) Comprehensive Access Plan (CAP) Basic Plan	877-842-4743	www.provider.uhc.com/pge *or* www.myuhc.com
American Specialty Health Network	800-678-9133	www.ashplans.com
Cancer Resource Services (CRS)	866-936-6002	www.urncrs.com
Nurse Advice Line	877-842-4743, then select Option 3	
Mental Health, Alcohol and Drug Care Program (Administered by ValueOptions)	800-562-3588	www.valueoptions.com
Prescription Drug Plan (Administered by Medco Health)	800-718-6590	www.medcohealth.com
Reimbursement Accounts (Administered by UnitedHealthcare)	877-842-4743	www.myuhc.com
Vision Plan (Administered by Vision Service Plan)	800-877-7195	www.vsp.com