Pacific Gas and Electric Company®

Flex Benefits 2006

ENROLLMENT GUIDE

PG&E @ Work Benefits 2006

Take Charge of Your Benefits!

Contents

Take Charge of Your Benefits

SUMMARY OF MATERIAL MODIFICATIONS *(October 2005)*

This guide is an overview of your Open Enrollment-related 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 *Management and A&T Employees*

On behalf of PG&E, I'm pleased to welcome you to Open Enrollment 2006.

This year's benefits enrollment period kicks off as PG&E celebrates its 100-year anniversary. While we celebrate the company's history, we are also looking forward to the future and positioning PG&E for the next 100 years.

The company offers a comprehensive benefits packet, but it's up to you to take an active role in understanding your benefits and making choices that maximize the value for your personal situation. We've mailed an enrollment packet — including this enrollment guide — to your home to help you make these important decisions and better prepare you for enrollment.

In this enrollment guide, you will find detailed information about the enrollment process and benefits changes for 2006, as well as tips on how you can save money on your health care-related expenses. Be on the lookout for the "Hot Tip" boxes found throughout the guide.

You have important decisions to make and a variety of options from which to choose. And we're here to help. If you have any questions about your benefit plan options or how they work, please feel free to contact PG&E's HR Service Center at **hrbenefitsquestions@pge.com**, or by calling company extension 8-223-2363, 415-973-2363 or 800-788-2363.

Sincerely,

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

Introduction

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 medical care facility mergers. Experts predict that the average cost increase to employers will be 11 to 14 percent for health care coverage in 2006.

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

PG&E Makes Cost-Saving Changes

In addition to giving you a variety of medical plan options from which to choose, PG&E is implementing two significant changes that will help you manage your medical costs. The first change affects both employees and retirees; the second change will benefit you when you retire and/or become eligible for Medicare.

First, the company is switching the administration of the self-funded medical plans (NAP, CAP and Basic Plan) from UnitedHealthcare to Blue Cross of California. This change will result in lower premium increases for these three plans in 2006. In addition, PG&E is passing along all of the company's net Medicare Part D savings to our Medicare members in the form of lower premium contributions.

Be sure to read about these changes and others in the "What's New for 2006" section of this guide.

Take Charge of Your Health Care Decisions

While PG&E is working hard to help keep your health care costs as low as possible, the company needs your help. One of the most important things that you can do can do to maximize the value of your health care benefits — and the dollars you spend on related services — is to take an active role in making smart 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 2006?

Consider deductibles and copayments for:

- primary care doctor, specialist, inpatient and outpatient hospital and emergency room visits for you and your covered dependent; **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 Blue Cross-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, so PG&E provides you with two ways to save. The Health Care and Dependent Care Reimbursement Accounts 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 27 and 28 of this guide.

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

If your medications are not covered by the plan, 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 cost for each plan I'm considering?

The annual FlexDollar cost for each plan available to you is shown on your 2006 Enrollment Worksheet. HMO costs are generally less expensive than those for the Blue Cross-administered plans (formerly administered by UnitedHealthcare), so your portion of the cost for these plans will generally be less, too. Therefore, if your doctors participate in an HMO, it may be beneficial to enroll in that plan.

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

Call the medical plan's member services number or visit its Web site to find out if your doctor is a participating physician (see outside back cover for plan contacts).

What resources are available to me?

Each plan offers a variety of disease management programs and wellness services, such as nurse help-lines, surgery decision tools, nutrition guides, personal health records, health risk assessment tools and other features. Be sure to visit each health plan's Web site to see what is offered.

In addition, the Comparison of Benefits Charts found in this guide show what the various medical plans cover for different 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 "Hot Tips" featured throughout this guide. They provide important bits of advice that can help you reduce your health care expenses, improve your health or simply get the most out of your medical plan.

Open Enrollment 2006

This year's Open Enrollment period begins on Friday, October 28, 2005, and ends on Thursday, November 10, 2005. During this time, you'll have the opportunity to make changes to your PG&E benefits and select the best options for your individual needs. On October 28, you'll receive an email with enrollment information and a link to the online enrollment system. You will be able to make your enrollment elections online or via the automated phone enrollment system. **Please note:** PG&E Corporation employees can only enroll online, and Corporation employees on leave of absence must enroll using a paper enrollment form.

This guide provides you with updates on plan changes for 2006, as well as comprehensive information aimed at helping you maximize the value of your PG&E-sponsored Flex Benefits.

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 extra vacation days in 2006, you need to go through the enrollment process. Otherwise, you don't need to enroll and you will automatically receive the "Default Flex Coverage" described on page 10. Just be sure to review the following:

- Your current medical plan's availability and annual Flex cost for 2006, as shown on your Enrollment Worksheet
- Your dependents' eligibility (see pages 16 and 17)
- "What's New for 2006" (see pages 5-8)
- Plan changes (indicated in bold on the Comparison of Benefits charts that begin on page 30).

Taking these easy steps will help you decide whether your current Flex Benefits coverage, or different coverage, is best for you.

IMPORTANT

Open Enrollment begins on **Friday, October 28, 2005,** and ends on **Thursday, November 10, 2005.**

What's NEW for 2006

Notice of Creditable Coverage (NOCC)

The Notice of Creditable Coverage (NOCC), enclosed in your enrollment packet, is intended for members who are eligible, or will be eligible, for Medicare in 2006. The NOCC attests that the prescription drug coverage provided by PG&E's medical plans is at least as good as, or better than, the new Medicare Part D basic benefit. It also contains information that may be important to members on Medicare, or members who will be eligible, for Medicare in 2006.

If you or your dependents will be eligible for Medicare in 2006, you should retain the NOCC for your records. If not, this document won't apply to you.

Blue Cross Replaces UnitedHealthcare

As recently announced in various PG&E communications, Blue Cross of California will be replacing UnitedHealthcare as the plan administrator for PG&E's self-funded medical plans — including the Network Access Plan (NAP), the Comprehensive Access Plan (CAP) and the Basic Plan.

Why PG&E Is Making the Change

Lower costs and better service — that's what PG&E believes will result by changing to Blue Cross of California. While this doesn't mean the rates will be lower than last year, it does mean that the 2006 rate increases will be smaller. In addition, Blue Cross has a track record of providing great service. For PG&E members, this should translate to faster and more accurate claims processing and better overall customer service. Blue Cross members also benefit by having access to one of the largest provider networks in California. In fact, more than 95 percent of providers in the UnitedHealthcare network are also in the Blue Cross network. So, it's very likely that your current physicians are in the new network. What's more, many providers not currently available through UnitedHealthcare may now be available through Blue Cross.

Given Blue Cross of California's reputation for quality and customer service, this should be a positive change for both employees and the company.

Plan Benefits to Remain the Same

The change to Blue Cross of California should not significantly affect the majority of employees currently enrolled in the UnitedHealthcare plans. All of the existing covered services, copayments, coinsurance and deductibles for the NAP, CAP and Basic Plan will remain the same. None of the plan provisions are changing. In addition, the plan administrators for mental health/substance abuse benefits and prescription drug benefits will continue to be ValueOptions for the mental health/substance abuse program and Medco Health for prescription drugs.

Largest Provider Network in California

Blue Cross' California network includes more than 45,000 physicians and 400-plus hospitals participating in its Blue Cross PPO (Prudent Buyer) network. For members who live or travel outside of California, the "BlueCard" program is available, providing nationwide access to all of the Blue Cross/Blue Shield PPO networks of doctors and hospitals (except the Blue Shield of California network).

IMPORTANT

The new Blue Cross-administered plans should not be confused with the Blue Shield HMO plan, which PG&E introduced to its members beginning in 2005. They are separate and distinct medical plan options.

To find out if your doctors are part of the Blue Cross PPO (Prudent Buyer) or BlueCard networks, review Blue Cross' provider directories at **http://www.bluecrossca.com/clients/pge**, or call Blue Cross at 800-964-0530. If, by chance, your physicians are not included in either of the networks, you do not necessarily have to change doctors. Instead, you can do one of the following:

1. Nominate your doctor(s) for participation in either network by completing the appropriate provider nomination form (PPO Network Provider Nomination Form or BlueCard Provider Nomination Form). Both forms can be obtained on Blue Cross' Web site, or by calling Blue Cross. Please keep in mind that the nomination/application process usually takes about four to six months, and it cannot be guaranteed that a contracting arrangement between your doctor and Blue Cross will result.

- or -

2. Continue to see your current doctor. If you are enrolled in the Network Access Plan (NAP), eligible expenses will be covered at a lower reimbursement rate under the NAP Non-Network benefit provisions. As always, members of the Comprehensive Access Plan (CAP) and the Basic Plan can use any doctor they want, although members may be "balance-billed" for charges above those that are considered "reasonable and customary" when seeing non-network doctors.

In early 2006, Blue Cross will send its PG&E members a welcome package with important information about claims procedures, medical management and disease management services.

What You Need to Do

If you're currently enrolled in a plan administered by UnitedHealthcare (NAP, CAP or Basic Plan), you will automatically remain in the same plan — to be administered by Blue Cross — in 2006, unless you select a different plan during the Open Enrollment period. You will receive a new Blue Cross identification card in early January.

If you don't want to stay in your current plan and if PG&E offers other medical plans in your area (as determined by your home ZIP code), you must actively enroll during Open Enrollment to select a different plan.

Transition of Care Benefits

Blue Cross has a "Transition Assistance Program" that will allow for continuity of care for UnitedHealthcare members who have ongoing treatment needs at the time of the switch to Blue Cross. If you or any eligible dependents are pregnant or undergoing an active course of treatment for an acute or serious chronic condition that will extend beyond January 1, 2006, you may qualify for transition assistance. Applications for this program will be available December 1, 2005, and can be obtained by calling Blue Cross customer service or via Blue Cross' custom PG&E Web site. As administrator, Blue Cross will make all determinations of eligibility for this program.

For More Information on Blue Cross

- Visit Blue Cross' custom Web site for PG&E members at **www.bluecrossca.com/clients/pge**.
- Call Blue Cross' new toll-free number, reserved exclusively for PG&E members at 800-964-0530.
- Visit PG&E's Benefits Web site at **wwwhr/Benefits**.

HMO Changes

PacifiCare Acquired by UnitedHealthcare

You may have heard that UnitedHealthcare is purchasing the PacifiCare HMO. PG&E has been informed that there will not be any operational changes to PacifiCare for 2006 as a result of UnitedHealthcare's acquisition, and that the HMO's network and benefits will continue with uninterrupted service. For additional information about PacifiCare, please call the HMO directly at the telephone number listed on the back cover of this guide.

Other HMO Changes

Some of the HMOs are making changes to their service territories and primary care provider networks in 2006. The information provided in this guide is current as of October 2005. 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.

No Wait to Join Dental 2

In 2006, the one-year waiting period that is currently required to switch from the Dental 1 plan to the Dental 2 plan is being eliminated. Flex employees enrolled in Dental 1 will now be able to switch directly to Dental 2 for the upcoming plan year, instead of having to enroll in the Transition Plan for one year before being allowed to make the switch.

If you are currently enrolled in the Transition Plan, you'll need to actively enroll to select which dental plan you want for 2006 — Dental 1 or Dental 2. If you don't enroll, your dental coverage for 2006 will automatically default to Dental 1, with your covered dependents remaining the same as in 2005.

Life Insurance Rate Reduction Ending

The Flex life insurance rate reduction that went into effect in 2004 will end on December 31, 2005. As a result, life insurance rates will return to the same levels that were previously in effect prior to the rate reduction.

The two-year rate reduction was 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 were used to provide Flex employees with a temporary 5.5 percent premium reduction for the 2004 and 2005 plan years.

The Flex life insurance rates for 2006 can be found on page 25.

FlexDays Replaced by New Vacation Buy Plan

In 2006, the FlexDay option is being replaced with a new, more flexible vacation purchase option — the Vacation Buy Plan. Instead of electing FlexDays through the Flex Plan, the utility's Management and Administrative and Technical (A&T) employees will now be eligible to use pre-tax salary dollars to purchase up to five additional vacation days — called "Vacation Buy Days" — during Open Enrollment. Although the option to purchase Vacation Buy (VB) Days will appear on your Flex enrollment worksheet, it will not be part of the Flex Plan. Accordingly, employees may not use FlexDollars to fund the purchase of VB Days; VB Days may only be purchased with pre-tax salary dollars. Unused FlexDollars will continue to be paid out to you at the end of the year if your FlexDollar allotment exceeds the cost of your Flex elections.

Like FlexDays, the cost of a VB Day is based on your basic salary for an eight-hour workday as of September 30 of the current year. The cost of a VB Day will not change even if you receive a salary increase during the period between Open Enrollment and your actual usage of the VB Day. VB Days must be purchased in eight-hour increments. The purchase cost will be spread out over 12 months with an equal pre-tax salary deduction taken each month. Deductions for A&T employees will be taken from the second paycheck of each month.

Like FlexDays, VB Days must be used in the upcoming calendar year. However, unlike FlexDays, you will not have to use up any current, deferred or service anniversary vacation prior to using VB Days. VB Days can be used at any time, as long as the necessary supervisory approvals are obtained and all the regular guidelines for time off are observed. VB Days must be used in increments of four hours. Any unused VB Days at the end of the year will be automatically paid out in January of the next year. VB Days will be paid out at the same rate at which they were purchased.

If you terminate employment, retire, transfer to a bargaining unit position mid-year or otherwise cease to be in a Flex-eligible position, and you have used VB Days that have not been fully funded, you will be responsible for paying the value of those unpaid VB Days. If payment is not made in accordance with PG&E's billing practice, the balance owed will be sent to collections.

New Administrator for Flexible Spending Accounts (HCRA and DCRA)

Effective January 1, 2006, Ceridian will replace UnitedHealthcare as plan administrator for the Flexible Spending Accounts — the Health Care Reimbursement Account (HCRA) and the Dependent Care Reimbursement Account (DCRA). Ceridian will continue to offer direct deposit as well as automatic reimbursement of out-of-pocket expenditures for Blue Cross and Medco prescription claims. In addition, dental and vision out-of-pocket expenses will be eligible for the automatic reimbursement feature.

Employees who enroll in an HCRA or DCRA during Open Enrollment will receive confirmation letters from Ceridian in early January 2006. The Web site for new participants will be available on January 1, 2006.

Special HIPAA Enrollment Rights for Mid-Year Changes

Effective January 1, 2006, if you get married or have a newborn or newly adopted child, or if your spouse or another dependent loses health care coverage, you may enroll yourself and any eligible dependents in PG&E's health care plans. If you are already enrolled in a PG&E-sponsored medical plan, you will not only be able to add eligible dependents, but you will also be able to change medical plans mid-year if you experience one of these specific events. For more information about making mid-year changes, please refer to Change-in-Status Events on page 18.

PG&E Domestic Partnership Registry Changes

Effective August 1, 2005, PG&E closed its internal domestic partner registry. If your partnership is currently registered with PG&E, you will need to re-register with an outside municipality and then contact the HR Service Center to let the company know that you have appropriately registered your partnership. If you fail to to do so before the end of the year, your domestic partner benefits coverage will be terminated effective January 1, 2006. For a list of municipalities that currently offer a domestic partner registry, please visit the company's HR intranet site at **wwhr/Benefits/Domestic Partners**, or contact the HR Service Center to request a listing.

HOT *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.

What You Need to Do for

OPEN ENROLLMENT

Five Easy Steps

1 **Review your enrollment options** on your personalized 2006 Enrollment Worksheet enclosed in your enrollment packet. The worksheet shows the Flex Plan options available to you for next year and the 2006 Flex cost for each option.

2 **Review your dependents' eligibility** (see pages 16 and 17 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 to request a "Notice of a COBRA Qualifying Event Notification." This form must be completed and returned to the HR Service Center within 60 days of the date on which your dependent loses coverage.

3 **Review the information in this Enrollment Guide**, including the "What's New for 2006" section and the Comparison of Benefits Charts.

4 **Decide whether you need to enroll:**

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

- make plan changes — e.g., if your current medical plan is no longer available in your area and you do not want to be automatically switched to the Blue Cross-administered plan (NAP or CAP) offered in your area
- add or delete dependents
- contribute to either of the Reimbursement Accounts — Health Care Reimbursement Account (HCRA) or Dependent Care Reimbursement Account (DCRA) — in 2006. Remember, any current HCRA or DCRA elections you have will not be carried over automatically into 2006, so think carefully before passing up these valuable benefits **or**
- purchase Vacation Buy Days (formerly called "FlexDays") for 2006.

See "Before You Enroll" on page 13 for important things to consider prior to enrolling.

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

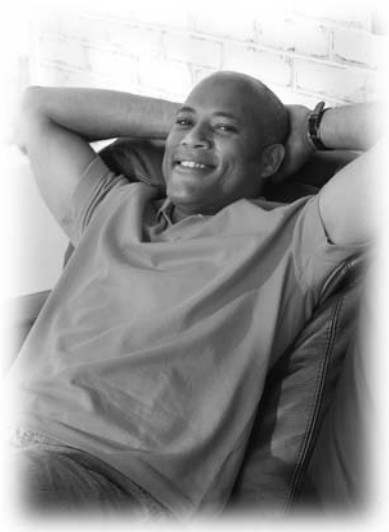
- you want to keep all your current health care and life insurance benefit elections and you have verified that your current medical plan is still available in your area OR you want to keep all your current health care and life insurance benefit elections, but your current medical plan will no longer be offered in 2006 and you want to be automatically switched to the Blue Cross-administered plan (NAP or CAP), shown on your Enrollment Worksheet
- you do not need to add or delete any dependents
- you do not want to contribute to the HCRA or DCRA in 2006 **and**
- you do not want to purchase Vacation Buy Days for 2006.

If you don't enroll, your current coverage will automatically default as described under "Default Flex Coverage" on page 10.

5 To enroll, log on to the new online enrollment system using the link that will be emailed to you on October 28, or call the HR Service Center's automated phone system. See page 11 for details on how to enroll.

Within 10 days, you will receive a confirmation statement verifying your choices, which will be effective January 1, 2006.

See "After You Enroll" on page 14 for additional information.



HOT Tip

You can't participate in the Reimbursement Accounts for 2006 (HCRA and DCRA) unless you enroll, so think carefully before passing up on these valuable benefits.

DEFAULT FLEX COVERAGE

- Your current 2005 medical coverage*, if your plan is still available in 2006 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 Blue Cross plan (NAP or CAP) available in your area, based upon your home ZIP Code
- Your current 2005 dental coverage (except Transition Plan will default to Dental 1)*
- Your current 2005 vision coverage*
- Your current 2005 life insurance coverage*
- No reimbursement account contributions
- Unused FlexDollars (if any) will be paid to you in cash as taxable income (see page 29).
- No Vacation Buy Days

** For you and your covered dependents, as listed on your 2006 Enrollment Worksheet.*

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 18).

How to Enroll

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

Online Enrollment

If you have a PG&E LAN ID and computer access, you can enroll online using the link that will be emailed to you on October 28. The online enrollment system is available 24 hours every day on any company computer or from home using your PG&E Citrix account during the October 28-November 10 Open Enrollment period.

- or -

Automated Phone System Enrollment
(Available to Utility Employees Only)

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 a 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. to 5:30 p.m. during the Open Enrollment period.

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

Whether you enroll online or over the phone, you will be sent a Confirmation Statement by company email within 10 working days, unless you are not actively at work. In this case, your Confirmation Statement will be mailed to your home.

HOT *Tip*

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.**

IMPORTANT

Any changes you make during Open Enrollment will be effective January 1, 2006. Changes cannot be made after the Open Enrollment period ends on Thursday, November 10, 2005. Enroll online or over the HR Service Center's automated phone system between Friday, October 28th and Thursday, November 10th.

YOUR AUTHORIZATION — PLEASE READ!

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

- acknowledge that you are responsible for reading the 2006 Flex Enrollment Guide and reviewing your Confirmation Statement
- acknowledge that you have received the Notice of Creditable Coverage included in your Open Enrollment package
- authorize the company to release Social Security numbers for you and your dependents 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 during 2006, even if your desired physician, hospital, medical group, or Independent Physician Association (IPA) does not participate in or terminates its relationship with your medical plan's network
- acknowledge that any current HCRA/DCRA and Vacation Buy Day elections cannot automatically roll forward into 2006 and that you must actively re-enroll to make new HCRA/DCRA and Vacation Buy Day elections for 2006
- agree to reimburse the company for the value of any Vacation Buy Days taken, but not paid for, should you terminate employment during 2006
- 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
- agree to follow the appeal process for your plan for any disputed benefit claims **and**
- agree 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 of absence during Open Enrollment and your leave extends into 2006, your Open Enrollment elections will take effect on January 1, 2006. You will also be given the opportunity to re-enroll upon your return to work if you notify the HR Service Center within 31 days of your return.

Before
YOU ENROLL

Considering Changing Medical Plans?

In most cases, you'll want to 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'll probably want to 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, such as chiropractic services or urgent care visits.

Selecting Primary Care Physicians

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, 2006. Each plan has its own policy and timeframe for changing primary care physicians retroactively.

For a directory of PCPs, call the member services number of the medical plan you're considering, or visit its Web site. Phone numbers and Web site addresses for the medical plans are listed on the outside back cover of this guide.

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 a governmental agency that maintains a domestic partner registry. PG&E no longer maintains an internal registry, as described under "What's New for 2006" on page 8. 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 PG&E's HR intranet (from the PG&E @Work Today home page, select Human Resources/Benefits/Domestic Partnerships).

IMPORTANT

During Open Enrollment, if you adding a newborn or adopted child to your health coverage for the upcoming year, make sure you also add the child to your health plans for the **current** year. You'll need to call the HR Service Center **within 60 days of the child's birth or adoption** to do this. If you don't, your child's coverage will not be effective until January 1, 2006. See pages 18 and 19 for more information.

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 pages 18 and 19 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 withdraw 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 (phone system not available to PG&E Corporation employees) — you will receive your confirmation statement by email within 10 working days.
- If you don't make any changes during Open Enrollment, you will receive a confirmation statement via company email by December 31, 2005, verifying your Flex coverage for 2006.
- Employees who are not actively at work will receive their confirmation statement at home via U.S. mail.

Membership Identification Cards

If you change medical plans or add dependents, you'll receive your new medical plan identification card(s) in January. In addition, all members enrolled in a Blue Cross-administered plan for 2006 will receive a new medical plan ID card.

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 Blue Cross plans also have the option of printing a copy of their ID cards off of Blue Cross' custom Web site for PG&E members at **www.bluecrossca.com/clients/pge**.

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 PG&E's HR Service Center immediately at company extension 8-223-2363, 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.

Find Valuable Information About Your Benefits On the Internet

Take advantage of our benefit plan providers' Internet Web sites to access information about your personal benefit plans. Plan Web site addresses are listed on the outside back cover of this booklet.

Some Web sites 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.

Employee Assistance Program (EAP)

PG&E's Employee Assistance Program (EAP) is another valuable company-sponsored benefit, provided at no charge to you and your family members. The EAP is available 24 hours per day, is completely confidential and offers counseling, education and referral services to help you address a wide array of of personal and work/life issues, including the following:

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

Contact the EAP at 888-445-4436, or visit **www.achievesolutions.net/pge**.

Eligibility

Who Is Eligible?

You are eligible to enroll in Flex Benefits 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 refer to your *Summary of Benefits Handbook*.

Eligible Dependents

Eligible dependents include:

- Your legally married spouse or registered domestic partner (see page 8 for updated information on the registry process for domestic partnerships)
- Your unmarried, dependent children who are under age 19, including step-children, children born during a domestic partner union, 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).

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. Call the HR Service Center at company extension 8-223-2363, 415-973-2363 or 800-788-2363 to drop any ineligible dependents.

Domestic Partner Tax Certification

If your enrolled domestic partner and/or his or her enrolled child(ren) are tax dependents, 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. Forms received after the end of the year will not be processed for 2006.

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 to reflect the coverage of the child, if applicable.

Domestic Partner Dependents

The State of California now considers a child born or adopted during the course of a registered domestic partnership to be a natural-born child to both partners — regardless of who is the child's biological birth-parent — and, consequently, such a child will continue to be considered an eligible tax dependent for purposes of health plan coverage in the event the domestic partnership is terminated. However, any child born to or adopted by your domestic partner **prior** to the establishment of your domestic partner union must be dropped from your PG&E health plans within 31 days should your registered domestic partnership legally come to an end.

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 a valid registry, or a former domestic partner (see page 8 for updated information on the registry process for domestic partnerships)
- Parents, step-parents, parents-in-law, grandparents and step-grandparents.

- Former step-children or your step-children from a former domestic partner, unless they were born or adopted during the course of the domestic partnership or you have been appointed permanent legal guardianship for them 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 or if they have not been approved by the company for continued coverage
- Married children or children who have entered the military (regardless of age or disability status)
- Children covered as dependents under the plan of another PG&E utility/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 for them by a court **or**
- A family member or domestic partner who is a PG&E utility or PG&E Corporation employee/retiree who has his or her own health coverage through PG&E or is eligible for Flex Benefits.

IMPORTANT

There are Penalties for Covering Ineligible Dependents!

Remember, it is your responsibility to be sure all the dependents you enroll for coverage are eligible. Dependents who lose eligibility during the year must be dropped within 31 days of the dependent's loss of eligibility. 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.

To drop ineligible dependents, call the HR Service Center at company extension 8-223-2363, 415-973-2363 or 800-788-2363.

Change-In-Status EVENTS

What's a Change-in-Status Event?

A change-in-status event is a life event that allows for changes in benefits elections after the plan year has begun. Only certain changes in status are permitted, due to restrictions imposed by federal registration governing the administration of pre-tax benefit plans like those offered at PG&E (see page 17 for eligible 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.

Any changes that you request typically must be consistent with your change-in-status event. For example, if a dependent child regains eligibility, you may add the child to your coverage; however, you cannot change plans. Accordingly, if you move out of your HMO's service territory, you may change plans, but you cannot add new dependents. The only exception is when you experience one of the events that trigger the new HIPAA Special Enrollment Rights, as described on page 8. Effective January 1, 2006, if you get married or have a newborn or newly adopted child, or if your spouse or another dependent loses health care coverage, you may enroll yourself and any eligible dependents in PG&E's health care plans, and you may also change medical plans.

PLEASE NOTE! The withdrawal of a provider, e.g., a doctor, medical group, hospital, etc., from your plan's network — or the fact that you want to use a particular provider who is not part of the network — is not an eligible change-in-status event. If any of your providers withdraw from or do not contract with 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 during the year if your desired provider does not contract with your plan.

IMPORTANT

Call the HR Service Center within 31 days of any eligible change-in-status event (60 days for births and adoptions) 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.

PG&E's HR Service Center

Company extension 8-223-2363, 415-973-2363 or 800-788-2363

Eligible Change-in-Status Events

Qualifying change-in-status events include the following:

- 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 health care coverage
- 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. If you don't, medical services you receive may not be covered. For more details, refer to your *Summary of Benefits Handbook*.

Important Information About Adding Newborn or Adopted Children

To ensure that your child has continuous health coverage from birth or adoption, you must **call the HR Service Center within 60 days of your child's birth or adoption** to add the child to your health plan(s). If you don't call within 60 days, your child's coverage will be cancelled and you won't be able to add the child until the next Open Enrollment period. Please note that if you add your child during Open Enrollment only, the child's coverage will not be effective until January and you may have a gap in coverage. In all cases, please call the HR Service Center promptly to add new children.

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 notify the company within 60 days of losing coverage and submit a "Notice of Qualifying Event" form to the HR Service Center.

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* or your *2005 Summary of Material Modifications*.

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 timeframe. 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 2006 Flex Plan year, your base allotment of $1699 FlexDollars and $250 in FlexDay Dollars has been combined into one base allotment of $1949 FlexDollars. You may also receive Sick Leave Usage Award bonus FlexDollars if you used fewer than 32 hours of sick leave between October 1, 2004, and September 30, 2005. In addition, if eligible, you may receive transitional life insurance bonus FlexDollars. **Please note:** PG&E Corporation employees are not eligible for the sick leave bonus.

Your 2006 Flex Enrollment Worksheet shows you the total amount of your FlexDollars for 2006. 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, 2005, you will receive a percentage of the total FlexDollar allotment, as indicated below, based on the number of straight-time hours you worked during the 12 months between October 1, 2004, and September 30, 2005.

If you change to full-time status between October 1, 2005, and the end of the year and you will remain full-time throughout 2006, call the HR Service Center to request full FlexDollars.

Hours worked 10/01/04 – 9/30/05	Percentage 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, 2004, and September 30, 2005, 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: the Dental 1 plan and the Dental 2 plan. Both plans are administered by Delta Dental and have different Flex prices. You may also decline dental coverage.

As described on page 7 under" What's New for 2006," there is no longer a one-year waiting period for Dental 1 members who want to switch to Dental 2. The Transition Plan is being eliminated in 2006. If you are currently enrolled in the Transition Plan, you'll need to actively enroll to select which dental plan you want for 2006 — Dental 1 or Dental 2. If you don't enroll, your dental coverage for 2006 will automatically default to Dental 1, with your covered dependents remaining the same as in 2005.

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.

For a list of Delta's participating dentists, call Delta Dental at 888-217-5323 or check its Web site at **www.deltadentalca.org**. The differences between Dental 1 and Dental 2 plan benefits are summarized on the following page.

IMPORTANT

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.

Delta Dental Benefits

Provision	Dental 1	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	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; also includes sealants for eligible dependents under age **16**	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 **16**
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

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

HOT *Tip*

Flex employees enrolled in Dental 1 can now switch directly to Dental 2 for 2006, instead of having to enroll in the Transition Plan for one year before being allowed to make the switch.

Vision

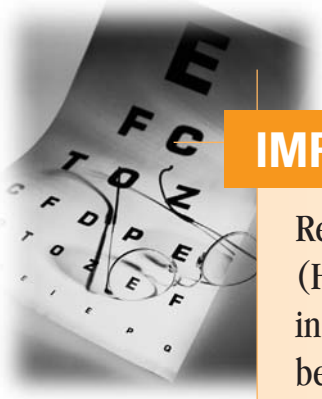
COVERAGE

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.

For a list of VSP providers, call VSP at 800-877-7195 or check its Web site 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 participating 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

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 2006 Flex Enrollment Worksheet for the Flex cost of additional coverage options.

Based on the Age You Turn on Your Birthday in 2006, your annual cost for each $1,000 in excess of $10,000 coverage is:		
Age	**Smoker**	**Non-Smoker**
Under 25	$ .66	$ .53
25-29	$ .78	$ .56
30-34	$ 1.02	$ .73
35-39	$ 1.14	$ .82
40-44	$ 1.38	$ 1.18
45-49	$ 2.20	$ 1.86
50-54	$ 3.36	$ 2.76
55-59	$ 5.62	$ 4.98
60-64	$ 8.47	$ 7.38
65-69	$15.30	$11.46
70 and older	$24.78	$17.12

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.

IMPORTANT

The temporary Flex life insurance rate reduction that went into effect in 2004 is ending on December 31, 2005.

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 2006 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 2006 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 on the date approved. Upon approval, your 2006 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 2006 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 2006, you must physically be at work for at least one day in 2006 to be covered at the higher amount.

IMPORTANT

If you want to increase your life insurance by two or more levels, you must provide proof of good health to Metropolitan Life.

Get FREE Help Preparing Your Will

PG&E employees who have elected more than $10,000 of employee life insurance in 2006 may once again take advantage of the special program offered by Hyatt Legal Plans (a MetLife company) that provides free will preparation assistance. 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 trusts. Please consult with an attorney to determine whether a living trust or a will is more appropriate for you.)

To use this program, simply contact Hyatt Legal Plans at 800-821-6400. 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.

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.

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. As described under "What's New for 2006," both accounts will be administered by Ceridian effective January 1, 2006.

You may contribute FlexDollars, pre-tax salary contributions, or a combination of both. 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 pay the provider and then file a claim for reimbursement from your account — which reimburses you with pre-tax dollars. Reimbursement checks will be mailed to your home, or you may elect the convenient option of having your reimbursement checks directly deposited to the banking institution of your choice. An added feature for HCRA participants is the "Automatic Reimbursement" option which allows you to have your out-of-pocket medical, dental, vision and/or prescription drug expenses (copayments, coinsurance, deductibles, etc.) automatically forwarded to Ceridian for reimbursement, thereby eliminating the need to submit claim forms for many health care expenses.

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 2006, you **must** enroll during Open Enrollment to indicate the *annual* amount you want to contribute.

Health Care Reimbursement Account (HCRA)

Having an HCRA allows you to pay for certain out-of-pocket health care expenses (such as hearing aids 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 Web site at **www.irs.gov**. In addition, although the IRS does not allow over-the-counter (OTC) drug expenses for tax deduction purposes, some OTC drugs may be eligible for reimbursement through the HCRA. Please call Ceridian at 877-799-8820 or check PG&E's HR Web site for information on which OTC drugs may be eligible for reimbursement.

IMPORTANT

Your HCRA/DCRA elections for 2005 cannot be carried over automatically into 2006.

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, ***unless*** such change in cost is triggered by a valid change-in-status event.

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

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 Web site 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 event, 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
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.

Unused FlexDollars

Any unused FlexDollars will be paid to you as taxable income. Employees will receive their unused FlexDollars as follows:

- **Management Employees** — paid out in December 2006 paycheck
- **Administrative & Technical Employees** — paid out in second paycheck in December 2006.

For employees who terminate employment before the end of the year, any Unused FlexDollars paid out will be prorated based on your date of termination.

Vacation Buy PLAN

As described under "What's New for 2006" on pages 7 and 8, the new Vacation Buy Plan is replacing the FlexDay option for utility employees. Unlike FlexDays, you may use the Vacation Buy (VB) Days you purchase at any time during the plan year without having to first use your current, deferred or service anniversary vacation. However, any VB Days purchased must be used by December 31, 2006. Any VB Days purchased but not used will automatically be cashed out as taxable income in your January paycheck (second biweekly check for A&T employees).

VB Days purchased may be taken in increments of four hours. If you terminate employment, retire, transfer to a bargaining unit position mid-year or otherwise cease to be in a Flex-eligible position, and you have used VB Days that have not been fully funded, you will be responsible for paying the value of those VB Days.

The pre-tax price for each VB Day is calculated from your base salary for an eight-hour workday as of September 30, 2005.

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

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

IMPORTANT

Through Open Enrollment, you may buy up to five extra vacation days, called Vacation Buy (VB) Days each year. VB Days purchased can be used immediately without having to use any of your current, deferred or service anniversary vacation first.

Comparison of Prescription Drug Benefits

FOR THE NAP, CAP AND BASIC PLANS
(DRUG BENEFITS ADMINISTERED BY MEDCO HEALTH)

The following table summarizes the prescription drug benefits for members enrolled in the Blue Cross-administered plans. Plan benefits are administered by Medco Health. Please note that the Medco Health out-of-pocket maximum must be met separately from the Blue Cross out-of-pocket maximum. Also, some drugs may not be covered or may require special authorization from your plan. For specific information about a plan's prescription drug coverage, call the plan's member services department directly, or visit its Web site at the Internet address listed on the outside back cover.

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 Web site at the Internet address listed on the outside back cover.

Prescription Drug Benefits for Blue Cross-Administered Plans

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)
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)
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 mail-order 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 mail-order plans, 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 HMO	Health Net HMO
General	Members access the Blue Shield HMO network; no pre-existing condition exclusions	Only providers affiliated with Health Net HMO; no pre-existing condition exclusions.
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	Included in office visit; no charge for allergy injections if no visit with physician	Included in office visit; no charge for allergy injections if no visit with physician
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; provided 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 (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 (through the plan): two times retail copay for up to a 90-day supply; no annual maximum; open formulary	RETAIL (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 (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*

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 North HMO	Kaiser South HMO
General	Services provided at Kaiser Permanente Hospitals and Offices by Kaiser Permanente doctors; no pre-existing condition exclusions	Services provided at Kaiser Permanente Hospitals and Offices by Kaiser Permanente doctors; no pre-existing condition exclusions
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 the 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*

Changes for 2006 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	PacifiCare HMO
General	Only providers affiliated with PacifiCare HMO; no pre-existing condition exclusions
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 copay for 30-day supply of self-injectable medication
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*

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 Blue Cross	Basic Plan Administered by Blue Cross
General	May use provider of choice or network providers; $100 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; no pre-existing condition exclusions *All plan benefits and out-of-pocket maximums are based on Eligible Expenses only.**	May use provider of choice; $250 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; no pre-existing condition exclusions *All plan benefits and out-of-pocket maximums are based on Eligible Expenses only.**
Hospital Stay	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
Skilled Nursing Facility	90% for semi-private room after 3 days in hospital; preauthorization required, $300 penalty if not obtained; excludes custodial care	70% after deductible only after 3 days in hospital; covers semi-private room; excludes custodial care
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 required for 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; excludes custodial care	100% after deductible; requires prior authorization; excludes custodial care
Hospice Care	90%; requires prior authorization, $300 penalty if not obtained; excludes custodial care	100% after deductible; requires prior authorization; excludes custodial care
Outpatient Physical Therapy	80%	70% after deductible
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health; see page 30 for details	Covered by separate prescription drug plan administered by Medco Health; see page 30 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	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 Blue Cross 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 Blue Cross of California. Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Blue Cross Member Services.*

Changes for 2006 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	Network Access Plan (NAP) Administered by Blue Cross	
	Network	**Non-Network**
General	Care provided by network providers. $100 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; no pre-existing condition exclusions	Care provided by non-network providers. $200 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; no pre-existing condition exclusions *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; excludes custodial care	70% for semi-private room after 3 days in hospital; preauthorization required, $300 penalty if not obtained; excludes custodial care
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, waived if admitted; 70% for outpatient surgery
Maternity Care	Covered as any other condition; preauthorization required for delivery stays beyond 48 hours for normal delivery or 96 hours for cesarean section; $300 penalty if not obtained	Covered as any other condition; preauthorization required for delivery stays beyond 48 hours for normal delivery or 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; excludes custodial care	70%; requires prior authorization, $300 penalty if not obtained; excludes custodial care
Hospice Care	90%; requires prior authorization, $300 penalty if not obtained; excludes custodial care	70%; requires prior authorization, $300 penalty if not obtained; excludes custodial care
Outpatient Physical Therapy	80%	70%
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health; see page 30 for details	Covered by separate drug plan administered by Medco Health; see page 30 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 Blue Cross 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 Blue Cross of California. Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Blue Cross 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 HMO	Health Net HMO	Kaiser North & South HMO	PacifiCare HMO
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	Email	Web Site	Phone Number
PG&E HR Service Center	HRBenefitsQuestions@pge.com	wwwhr	Company ext. 8-223-2363 415-973-236 or 800-788-2363
IRS Publications		www.irs.gov	800-829-3676
PG&E's ***Summary of Benefits Handboook***			

Member Services Contacts

Plan	Phone Number	Web Site
Blue Shield HMO	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 HMO	800-522-0088	www.healthnet.com
Kaiser (North and South) HMO	800-464-4000	my.kaiserpermanente.org/ca/pge
PacifiCare HMO	800-624-8822	www.pacificare.com
PG&E Medical Plans (Administered by Blue Cross) Network Access Plan (NAP) Comprehensive Access Plan (CAP) Basic Plan	800-964-0530	www.bluecrossca.com *or* www.bluecrossca.com/clients/pge
American Specialty Health Network	800-678-9133	www.ashcompanies.com
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 Ceridian)	877-799-8820	www.ceridian-benefits.com
Vision Plan (Administered by Vision Service Plan)	800-877-7195	www.vsp.com