Pacific Gas and Electric Company™

What's New For 2004

Health Care Plans

Summary of Material Modifications for Bargaining Unit Employees

Introduction

This booklet describes important changes to your health care plans that will become effective on January 1, 2004. This document is being provided to you as a supplement to the Open Enrollment materials that will be sent to you in about a month and also as an update, or "Summary of Material Modifications," to your Summary of Benefits Handbook. By providing you with detailed information about these changes in advance, it is our hope that you will have ample time to become familiar with the various changes and will be prepared to make well-informed benefit decisions when you receive your Open Enrollment materials in late October. Please keep this information for future reference throughout the year.

Open Enrollment For 2004

This year's Open Enrollment period is October 27 through November 7, 2003. You will receive enrollment instructions prior to the Open Enrollment period, along with information on which medical plans are available in your area.

Questions on the information in this brochure can be directed to the HR Service Center. The phone numbers are Company extension 223-2363, 415-973-2363 or 1-800-788-2363, or send your questions by e-mail to HRBenefitsQuestions@pge.com. You may also call the medical plans directly. A list of telephone numbers and websites is provided at the end of this brochure.

What's New for 2004

There will be many changes to the health care plans in 2004. Upcoming plan changes are summarized in the chart below.

CURRENT PLAN / PROVISION	WHAT'S NEW FOR 2004
Eligibility/Enrollment for Health Care Benefits	• New hires will be eligible to enroll in medical, dental, vision and reimbursement accounts within 31 days of hire • Late enrollment in UnitedHealthcare plans no longer allowed due to IRS restrictions
Medical Plan Contributions	• Full-time employees and LTDers will pay 3.75% of their medical plan premium • Part-time employees will pay 3.75% of their medical plan premium in addition to their part-time contribution • Contributions will be on a pre-tax basis
UnitedHealthcare Point of Service (POS) Plan	• Replaced by UnitedHealthcare Network Access Plan (NAP) • Same network of hospitals and doctors • New Cancer Resource Services (CRS) program
UnitedHealthcare Preferred Provider Organization (PPO) Plan	• Replaced by UnitedHealthcare Network Access Plan (NAP) • Same network of hospitals and doctors • New Cancer Resource Services (CRS) program
UnitedHealthcare Out-of-Area (OOA) Plan	• Replaced by UnitedHealthcare Comprehensive Access Plan (CAP) • New Cancer Resource Services (CRS) program
Health Maintenance Organizations (HMOs) • Health Net • Kaiser • PacifiCare	• Office copayments increasing from $5 to $10 • Some other copayments also changing (e.g., emergency room, mental health visits, prescription drugs – will vary by HMO) • Aetna HMO will no longer be offered
Prescription Drug Plan (for UnitedHealthcare members)	• Will provide additional incentives for using generic drugs and home delivery
Mental Health, Alcohol and Drug Care Benefits	• Increase in copayments for outpatient visits from $10 to $15 (ValueOptions) • Initial visit to psychiatrist for medication evaluation is free of charge (ValueOptions) • Kaiser members now eligible to receive inpatient or residential treatment for alcohol and drug abuse through ValueOptions
Employee Assistance Program	• Increase in number of visits per case from 3 to 6
Retiree Medical Benefits	• Retirees can re-enroll if they drop medical coverage • Change in eligibility requirements for retiree medical coverage • New program – the Retiree Premium Offset Account – to help eligible retirees pay Company medical plan premiums

Eligibility and Enrollment for Health Care Plans

New Hires Are Eligible Sooner for Health Plan Coverage

New hires will no longer have to wait six months before becoming eligible to enroll for medical, dental, and vision coverage, or to contribute to a Health Care or Dependent Care Reimbursement Account. Coverage for new hires will be effective the first of the month following receipt of a completed enrollment form, provided the form is received within 31 days from the date of hire. For example, if you are hired March 5 and you submit an enrollment form that's received by the Company on March 20, your coverage will be effective April 1. However, if your completed form is not received until April 4, your coverage will not be effective until May 1.

New hires who do not enroll within thirty-one days will be required to wait until the next Open Enrollment period to enroll, with coverage effective January 1st of the following year. (And don't forget to enroll newborn children within 60 days of the child's birth.)

Intermittent employees and other temporary employees who are not expected to become regular employees are not eligible for coverage.

Status Changes

The Internal Revenue Code restricts changes in enrollment outside of the annual Open Enrollment period for health plans with pre-tax contributions, unless there is a valid change-in-status event and the requested change is consistent with the event.

Prior to 2004, contributions were on a post-tax basis. Enrollment rules could be more flexible. For example, if you did not add eligible dependents to your health plans within 60 days of a birth or adoption, you could still "late-enroll"

dependents if you were enrolled in a UnitedHealthcare plan. This will no longer be an option.

In 2004, if you do not enroll a dependent within 60 days of a birth or adoption, or within 31 days of any other type of change-in-status event, you will need to wait until the next Open Enrollment period to add your dependents to your health plans, with coverage effective January 1st of the following year.

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

Eligible Change-in-Status Events include:

- 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-provided medical plan even if a court orders you to provide coverage.
- The birth or adoption of a child, or your court-ordered appointment of legal guardianship for a child
- A change in your spouse's/registered domestic partner's or dependent's employment that results in a gain or loss of health care coverage
- A change to or from full-time or part-time employment by you or your spouse/registered domestic partner or dependents, if health plan eligibility is affected
- An unpaid leave of absence taken by you or your spouse/registered domestic partner that significantly impacts the cost of your benefits
- The death of your spouse/registered domestic partner or a dependent child

- Your dependent child reaching the plan's age limit, getting married, or entering the military
- Your dependent child regaining eligibility
- A change of caregivers, or a change in the cost for the services of *a caregiver who is not a relative* (for DCRA purposes only)
- A move out of your HMO's service territory (applies to change of medical plan only)

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

Medical Plan Cost-Sharing Contributions

The Company and employees will share the cost of medical plan premiums starting in 2004. Full-time employees will pay 3.75% of the actual premium of the medical plan they select. Employee contributions will vary based on the medical plan and level of coverage elected (e.g., Self Only, Self and Spouse, etc.). Full-time employees will not be required to contribute to the costs of the dental and vision plans.

Employee contributions will be taken as a pre-tax payroll deduction from the second check of each month. This means that an employee's taxable income will be decreased by the amount of the payroll deduction. Therefore, the amount that your take-home pay is reduced will be less than the amount of your medical premium.

Cost-Sharing Example: Full-Time Employee

Lewis is a full-time employee. His monthly contribution to the Network Access Plan (NAP) for single coverage is $15.84, which is 3.75% of the actual monthly premium of $422.46 for the NAP plan.

Plan Premium x Cost-Sharing Percentage = Monthly Employee Contribution

$422.46 x .0375 = $15.84

Because the $15.84 is deducted from Lewis' paycheck on a pre-tax basis, his taxable income is lowered by his deduction. Assuming Lewis' tax bracket is 35%, he will pay $5.54 less in taxes.

Monthly Employee Contribution x Tax Bracket = Tax Savings

$15.84 x .35 = $5.54

So Lewis' net medical plan contribution – the difference between what he pays for his medical coverage and what he saves in taxes – is $10.30.

Monthly Employee Contribution – Tax Savings = Net Premium Contribution

$15.84 - $5.54 = $10.30

Part-Time Employees

Part-time employees currently make prorated contributions on a post-tax basis for medical, dental and vision coverage. In 2004, these contributions will be on a pre-tax basis.

The Company will continue to base its prorated medical plan contribution for part-time employees on the premium for the UnitedHealthcare plans (NAP/CAP), regardless of what plan the employee is actually enrolled in. Part-

time employees will pay the difference between the Company's prorated contribution and the premium for the medical plan they actually select, plus 3.75% of the premium for their selected medical plan.

The amount the Company contributes is based on the ratio of actual straight-time hours worked for the 12-month period from October 1st of the previous year to September 30th of the current year to the full-time hourly equivalent of 2080 hours. The Company will contribute an amount equal to this percentage multiplied by the cost of the UnitedHealthcare plans (NAP/CAP). Premiums for part-time new hires will be based on an assumed schedule of 36 hours of work for their first six months of employment. When the employee completes six months of service, the premiums will be recalculated based on the actual number of straight-time hours worked from their date of hire.

Cost-Sharing Example: Part-Time Employee

Kristine worked 1299 hours from 10/01/02 to 9/30/03 and elects Health Net for herself only. Her estimated 2004 monthly premium for Health Net self-only coverage is $302.49.

Step 1: Calculate the Company contribution percentage:

1299 hours / 2080 hours = 62%

Step 2: Calculate the Company contribution:

.62 X $422.46 (based on UnitedHealthcare NAP premium) = $261.93

Step 3: Calculate the employee contribution:

- $302.49 (Health Net premium) - $261.93 (Company contribution) = $40.56. This is Kristine's part-time contribution.
- $302.49 (Health Net premium) x .0375 (cost-sharing %) = $11.34. This is Kristine's additional cost-sharing contribution.
- $40.56 (part-time contribution) + $11.34 (cost-sharing contribution) = $51.90. This is Kristine's total monthly contribution for her medical plan premium.

Since part-time employees will now be able to contribute on a pre-tax basis instead of a post-tax basis, Kristine's net contribution is estimated to be $33.73, assuming a 35% tax rate, as follows:

Monthly Employee Contribution x Tax Bracket = Tax Savings

$51.90 x .35 = $18.17

Monthly Employee Contribution – Tax Savings = Net Premium Contribution

$51.90 - $18.17 = $33.73

Leaves of Absence

Employees on a leave of absence will also be required to pay medical plan cost-sharing contributions. Contributions will range from 3.75% to 100% of the medical plan premium, depending on the type of leave you are on and whether you are full-time or part-time. Your leave of absence package will explain your payment options while on leave.

Long-Term Disability (LTD)

Employees on Long-Term Disability (LTD) will be required to pay 3.75% of their medical plan premiums. Medical premium deductions will be taken on a pre-tax basis from the employee's Long-Term Disability check, provided the employee is receiving LTD payments. Dental and vision coverage will continue to be provided by the Company at no cost to LTD employees.

Monthly Cost-Sharing Contribution Amounts for 2004

The chart on the following page lists the monthly employee cost-sharing contributions, by plan, for full-time employees and employees on Long-Term Disability*. Part-time employees and employees on leave may pay more than the amounts shown below. Your 2004 Enrollment worksheet will show the appropriate premium for each plan you are eligible to join, based on your personal employment status.

2004 Monthly Cost-Sharing Amounts

PLAN	SELF ONLY	SELF & SPOUSE/ DOMESTIC PARTNER	SELF & CHILDREN	SELF, SPOUSE/ DOMESTIC PARTNER & CHILDREN
NAP	$15.84	$33.26	$28.51	$45.94
CAP	$15.84	$33.26	$28.51	$45.94
KAISER	$10.35	$21.75	$18.64	$30.03
HEALTH NET	$11.34	$23.82	$20.41	$32.89
PACIFICARE	$11.34	$23.82	$20.42	$32.90

* Note: This chart does not include contribution amounts for employees on Long-Term Disability who are eligible for Medicare. Those amounts will be included, if applicable, with your Open Enrollment materials.

Two New UnitedHealthcare Plans Replacing POS, PPO and OOA Plans

The Point of Service (POS) Plan, the Preferred Provider Organization (PPO) Plan, and the Out-of-Area (OOA) Plan, all administered by UnitedHealthcare, are being replaced with two newly designed plans – the Network Access Plan (NAP) and the Comprehensive Access Plan (CAP) – that reflect current practices in the health plan market place. These new plan designs are intended to make the plans easier to use and more up-to-date with what other employers are offering. A summary of benefits for each of the new plans can be found on the charts provided at the end of this section. These benefit summaries will also be included with your Open Enrollment materials.

As a rule of thumb, in most areas where the Point of Service (POS) Plan and the Preferred Provider Organization (PPO) Plan are currently offered, the Network Access Plan (NAP) will be the new UnitedHealthcare plan offered. Likewise, in most areas where the Out-of-Area (OOA) Plan is currently offered, the Comprehensive Access Plan (CAP) will most likely be the new plan offered. Your Open Enrollment materials will identify the plans available to you.

Plans Administered by UnitedHealthcare

In 2004, the medical plans administered by UnitedHealthcare will be:

UNITEDHEALTHCARE PLAN:	AVAILABLE TO:
Network Access Plan (NAP)	• Employees and their dependents who meet access standards
Comprehensive Access Plan (CAP)	• Employees and their dependents who don't meet the NAP access standards

How the Plans Work

Network Access Plan (NAP). The Network Access Plan (NAP) is considered a preferred provider organization (PPO). However, this new plan has a different design than PG&E's current PPO Plan.

One of the advantages of the Network Access Plan (NAP) is that the plan allows members to see specialists directly, without first seeking authorization from a primary care physician. The NAP encourages the use of a nationwide network of providers by offering a higher level of reimbursement when members use network providers. NAP members still have the option of using a non-network provider, but will receive a reduced level of reimbursement when they do so.

Comprehensive Access Plan (CAP). Comprehensive Access Plan members receive the same level of benefits that NAP members receive, except that their level of benefit reimbursement will not be reduced if they use non-network providers. However, as an added incentive to use network providers, CAP members will receive network discounts when they do so. In addition, network providers cannot bill CAP members any costs over and above the established payment schedule with UnitedHealthcare. CAP members will also have the same types of covered services, including preventive services such as routine physical examinations, as members of the NAP plan.

Same Networks As In 2003

The NAP plan will use the same network of hospitals, doctors and other health care professionals that is currently being used by both the Point of Service and Preferred Provider Organization Plans. This means that existing POS or PPO Plan members will not have to change doctors. However, this does not mean that changes to the network's providers will not occur. UnitedHealthcare reviews its network needs on an ongoing basis, and doctors and hospitals also review their contracts with medical plans. If UnitedHealthcare and your providers do not renew their existing agreements, your providers could drop out of the network.

Eligibility

UnitedHealthcare will use its standard criteria for determining who will be eligible to enroll in the Network Access Plan (NAP). Members who meet the following access criteria will be eligible to join the NAP. Members who do not meet these criteria will be eligible to enroll in the Comprehensive Access Plan (CAP).

AREA	NETWORK ACCESS PLAN (NAP) ACCESS STANDARDS
Urban	• One hospital within 10 miles • Two primary care physicians within 8 miles • Two OB/GYNs within 8 miles • Two pediatricians within 8 miles
Suburban	• One hospital within 15 miles • Two primary care physicians within 15 miles • Two OB/GYNs within 15 miles • Two pediatricians within 15 miles
Rural	• One hospital within 30 miles • Two primary care physicians within 30 miles • Two OB/GYNs within 30 miles • Two pediatricians within 30 miles

Use of Primary Care Physicians

PG&E continues its commitment towards coordination of medical care. When the concept of managed care was first introduced in the early 1990s, the practice of using primary care physicians as a coordinator of care became common.

Primary care physicians are internists, family practitioners, general practitioners or pediatricians. UnitedHealthcare does not consider an OB/GYN to be a primary care physician.

The Network Access Plan (NAP) will not require you to select a primary care physician. Nor will you need to get a referral from a primary care physician in order to see a specialist. Nevertheless, you may want to continue or establish a relationship with a primary care physician who can coordinate your overall medical care.

The NAP plan has a lower copayment of $10 for visits to primary care physicians than the $20 copayment for visits to specialists, but allows you to see specialists without a referral. This newer approach to coordinated care, which is being embraced by many employers, allows direct access to specialists.

Referrals to Specialists

None of the medical plans administered by UnitedHealthcare will require a referral to see a specialist.

Basic/Major Terms No Longer Apply

Two of the current plans, the Preferred Provider Organization Plan and the Out-of-Area Plan, have benefit designs called Basic/Major benefits. However, the practice of differentiating between Basic and Major benefits is outdated

and, thus, not typically used by modern-day health plans. The new, simpler design, which does not differentiate between Basic and Major benefits, will be easier to use.

Example:

COVERED SERVICE	2003 PPO and Out-of-Area PLANS	2004 NAP and CAP PLANS
X-RAY AND LAB TESTS	• Basic pays 100% of the first $200 each calendar year • Major pays 80% after deductible thereafter	Plans pay 90% (after deductible, if applicable)

Deductibles in 2004

There will be no deductibles in 2004 for NAP members who use network providers or for CAP members. NAP members who don't use network providers will have a deductible of $200 per person and $600 per family.

Deductibles Effective 2005

Effective January 1, 2005, the annual deductible will be $100 per person with a $300 family maximum for Network Access Plan (NAP) members who use network providers and for Comprehensive Access Plan (CAP) members. NAP members who don't use network providers will continue to have a deductible of $200 per person and $600 per family.

Annual Out-of-Pocket Maximums

An out-of-pocket maximum is the maximum amount you pay each calendar year for covered expenses, including deductibles. For Network Access Plan (NAP) members who use network providers and for Comprehensive Access Plan (CAP) members, the annual out-of-pocket maximum is $750 per person with a family maximum of $1,500. NAP members who don't use network providers will have an annual out-of-pocket maximum of $1,000 per person with a $2,000 family maximum.

Charges for non-covered services, charges above Reasonable and Customary Charges, and penalties for non-notification do not apply toward the annual out-of-pocket maximum.

Chiropractic Care

Pre-approval for chiropractic care is required for members of the Network Access Plan (NAP). For members of the Comprehensive Access Plan (CAP), pre-approval is necessary after the initial visit to a chiropractor. Chiropractic care will be reimbursed at 80% when visits are to a network provider and the care is approved by American Specialty Health Network (ASHN).

If NAP members do not obtain approval from American Specialty Health Network, benefits will be reimbursed at 70% for up to 15 visits for Medically Necessary care. CAP members will only have the initial visit reimbursed at 80% if subsequent visits are not approved.

You obtain approval from American Specialty Health Network (ASHN) by calling 1-800-678-9133. You can also find out which chiropractors are network providers by calling ASHN or visiting the ASHN website at www.ashplans.com.

Acupuncture

Acupuncture services received from an M.D. or licensed acupuncturist will be covered at 80% for up to 20 visits per year for Network Access Plan (NAP) members who use a network acupuncturist, and for members of the Comprehensive Access Plan (CAP).

If NAP members do not use a network acupuncturist, the reimbursement rate will be 70% for up to 15 visits of Medically Necessary care.

Transplant Services

Organ and tissue transplants are covered at 100% for Network Access Plan (NAP) members and Comprehensive Access Plan (CAP) members when preauthorized and when performed at a Designated United Resource Network Facility.

If NAP members use a facility other than a Designated United Resource Network Facility, reimbursement will be limited to 70% of Reasonable and Customary expenses. Preauthorization is still required.

Cornea transplants do not require use of a Designated United Resource Network Facility.

To obtain information on Designated United Resource Network Facilities, contact UnitedHealthcare's Care Coordination at 1-877-842-4743.

Supplemental Accident Benefit and Deductible Accident Provisions No Longer Apply

The Supplemental Accident Benefit and Deductible Accident Provisions that are part of the current Point of Service, Preferred Provider Organization and Out-of-Area Plans do not apply to the Network Access Plan (NAP) or the Comprehensive Access Plan (CAP).

Cancer Resource Services (CRS) for UnitedHealthcare Members

A new program – Cancer Resource Services (CRS) – is now available to members who have selected UnitedHealthcare as their medical plan administrator. Cancer Resource Services is designed to help members get the information they need to understand their cancer diagnosis and their treatment options. In addition, experienced CRS nurses can help members choose the best physician and cancer center for treatment of a specific kind of cancer.

Through this program, members also have access to top cancer specialists at premier cancer centers across the country and their clinical trials. These providers are considered "preferred network providers" for members enrolled in the NAP plan. CAP members are also eligible to use the services of CRS at their standard level of coverage for the services performed. Members may also be eligible for reimbursement for travel and lodging expenses when getting care at a CRS cancer center. To make the most of this new benefit, however, members must call CRS **before** receiving care at a participating CRS cancer center.

For additional information about Cancer Resource Services and participating cancer centers or for questions about a cancer diagnosis, please call a CRS nurse consultant toll-free at 1-866-936-6002. Nurses are available from 7 a.m. to 7 p.m. Central Time, Monday through Friday, excluding holidays. Or visit the Cancer Resource Services website at www.urncrs.com for more information about the products and services now available. This program is voluntary and free of cost.

Network Access Plan (NAP)

The chart below summarizes the benefits of the Network Access Plan (NAP).

Provisions	*Network Access Plan (NAP)* *Administered by UnitedHealthcare*	
	Preferred (Network)	**Non-Preferred (Non-Network)**
Deductible	2004 - None 2005 and thereafter - $100 per person; $300 family maximum	2004 - $200 per person; $600 per family 2005 and thereafter - $200 per person; $600 per family
Annual Out-of-Pocket Maximum	$750 per person; $1500 family maximum	$1000 per person; $2000 family maximum
Lifetime Maximum	None	None
Hospital Stay	100% after a $100 copay Preauthorization required for non-emergency care; $300 penalty if not obtained	70% Preauthorization required for non-emergency care; $300 penalty if not obtained
Skilled Nursing Facility	90% Preauthorization required; $300 penalty if not obtained	70% Preauthorization required; $300 penalty if not obtained
Emergency Room Care	$35 copay per visit. Waived if admitted.	$35 copay per visit. Waived if admitted.
Outpatient Hospital	$35 copay per visit. Waived if admitted.	70%
Maternity Care	Covered as any other condition. Preauthorization of delivery stays beyond 48 hours for normal delivery and 96 hours for cesarean section; $300 penalty if not obtained	Covered as any other condition. Preauthorization of delivery stays beyond 48 hours for normal delivery and 96 hours for cesarean section; $300 penalty if not obtained
Well-Baby Care	Covered as any other condition	70%
Office Visits	Primary care - $10 copay Specialists (including OB/GYN) - $20 copay	70%
Urgent Care Visits	$10 or $20 copay, depending on if Primary care or Specialist visit	70%
Routine Physical Examinations	$10 or $20 per visit, depending on if Primary care or Specialist visit; lab/X-rays covered separately	70%
Immunizations and Injections	95%	70%
Eye Examinations	Covered under separate plan	Covered under separate plan
X-rays and Lab Tests	90%	70%
Pre-Admission Testing	95%	70%
Home Health Care & Home Hospice Care	90% Preauthorization required; $300 penalty if not obtained	70% Preauthorization required; $300 penalty if not obtained
Outpatient Physical Therapy	80%	70%
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health. (See page 23)	Covered by separate drug plan administered by Medco Health. (See page 23)
Mental Health	Covered by separate Mental Health Program administered by ValueOptions	Covered by separate Mental Health Program administered by ValueOptions
Inpatient and Outpatient Alcohol and Drug Care	Covered by separate Alcohol and Drug Care Program administered by ValueOptions	Covered by separate Alcohol and Drug Care Program administered by ValueOptions
Chiropractic Care	80% for care approved by American Specialty Health Network	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.
Infertility Treatment	Covered as any other condition up to $7,000 lifetime. Balances from prior plans carry forward.	Covered as any other condition up to $7,000 lifetime. Balances from prior plans carry forward.
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
Transplant Services	100% when performed at a Designated United Resource Network Facility. Preauthorization required for preferred coverage.	70% if not performed at a Designated United Resource Network Facility. Preauthorization required for coverage.

Comprehensive Access Plan (CAP)

The chart below summarizes the benefits of the Comprehensive Access Plan (CAP).

Provisions	*Comprehensive Access Plan (CAP)* *Administered by UnitedHealthcare*
Deductible	2004 - None 2005 and thereafter - $100 per person; $300 family maximum
Annual Out-of-Pocket Maximum	$750 per person; $1500 family maximum
Lifetime Maximum	None
Hospital Stay	100% after a $100 copay Preauthorization required for non-emergency care; $300 penalty if not obtained
Skilled Nursing Facility	90% Preauthorization required; $300 penalty if not obtained
Outpatient Hospital and Emergency Room Care	$35 copay per visit. Waived if admitted.
Maternity Care	Covered as any other condition. Preauthorization of delivery stays beyond 48 hours for normal delivery and 96 hours for cesarean section; $300 penalty if not obtained
Well-Baby Care	Covered as any other condition
Office Visits	Primary care - $10 copay Specialists (including OB/GYN) - $20 copay
Urgent Care Visits	$10 or $20 copay, depending on if Primary care or Specialist visit
Routine Physical Examinations	$10 or $20 copay, depending on if Primary care or Specialist visit, lab/X-rays covered separately
Immunizations and Injections	95%
Eye Examinations	Covered under separate plan
X-rays and Lab Tests	90%
Pre-Admission Testing	95%
Home Health Care & Home Hospice Care	90% Preauthorization required; $300 penalty if not obtained
Outpatient Physical Therapy	80%
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health. (See page 23)
Mental Health	Covered by separate Mental Health Program administered by ValueOptions.
Inpatient and Outpatient Alcohol and Drug Care	Covered by separate Alcohol and Drug Care Program administered by ValueOptions
Chiropractic Care	80% for Medically Necessary care. Preauthorization by American Specialty Health Network required after initial visit
Acupuncture	80% for up to 20 visits per year from licensed acupuncturist or M.D.
Infertility Treatment	Covered as any other condition up to $7,000 lifetime. Balances from prior plans carry forward.
Durable Medical Equipment	80% Preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained
Transplant Services	100% Preauthorization and use of Designated United Resource Network Facility required for coverage.

Health Maintenance Organizations (HMOs)

Kaiser, Health Net and PacifiCare will continue to be offered as HMO options to employees who reside in the appropriate service areas.

The Aetna HMO will no longer be offered. If you are enrolled in Aetna and do not select a new plan during Open Enrollment, you will be automatically switched to the Network Access Plan (NAP) or the Comprehensive Access Plan (CAP), depending on where you live.

Copayments in the HMOs are increasing to reflect the rising costs of health care. The copayments for office visits will increase from $5 to $10. There will also be increases in copayments for other services, such as prescription drugs and emergency room care. These increases in copayments will vary by HMO. The copayments for HMO services in 2004 will be listed on the comparison charts included with your Open Enrollment information.

There is additional information on HMOs in the section of this brochure on Mental Health, Alcohol and Drug Care Benefits (see page 24).

Employees on Long-Term Disability (LTD)

If you are on Long-Term Disability but you are not eligible for Medicare, you may enroll yourself and your dependents in the UnitedHealthcare plans or HMOs available in your area.

If you are on Long-Term Disability and you are eligible for Medicare, you may enroll in the Comprehensive Access Plan (CAP) administered by UnitedHealthcare or in one of the HMO plans available to Medicare participants in your area. The Company is the secondary payor of your medical benefits, with the exception of prescription drug benefits. If you enroll in the CAP plan, the Company is the primary payor of prescription drug benefits because

Medicare does not cover prescription drugs. Your non-Medicare-eligible covered dependents will be automatically enrolled in the appropriate UnitedHealthcare plan for non-Medicare members (NAP or CAP), depending on where you live.

Prescription Drug Plan (For Members of UnitedHealthcare-Administered Plans)

A couple of important changes are being made to the Prescription Drug Plan administered by Medco Health effective January 1, 2004. This plan provides benefits to members enrolled in the Network Access Plan (NAP) and the Comprehensive Access Plan (CAP). Members enrolled in Health Maintenance Organizations (HMOs) have drug coverage through their HMOs.

Employees on Long-Term Disability (LTD) who are enrolled in a UnitedHealthcare plan also receive prescription drug benefits through this plan. Because Medicare does not cover prescription drugs, this plan is the primary payor of prescription drug benefits for employees on LTD who are enrolled in Medicare.

Home Delivery Incentive

Prescription drugs purchased at a participating retail pharmacy will continue to be reimbursed for up to three 30-day supplies at 85% for generic drugs and 75% for brand-name drugs. **However, for retail refills beyond 90 days, the reimbursement rate will be 80% for generic and 70% for brand-name drugs**. For example, members will be reimbursed at 85% for the initial 30-day generic prescription as well as for two 30-day generic refills at a retail pharmacy. If the member requests a fourth prescription at a retail pharmacy, the reimbursement rate will drop to 80% because the 90-day limit will have been exceeded. Therefore, **it is suggested that members use the home-delivery service for refills beyond 90 days.**

Generic Incentive

Another important change is that for all prescription drug purchases, whether at a retail drug store or through home delivery, members will be responsible for paying the difference between the price of a generic prescription drug and a brand prescription drug, plus coinsurance, if purchasing a brand-name drug when a generic is available. Here's an example of how the new "pay the difference" provision will work:

Example of Brand-Name Purchase Versus Generic:

Al purchases a 30-day supply of Mevacor, a brand-name prescription drug. He chooses not to use the generic alternative, Lovastatin.

	GENERIC	***BRAND-NAME***
Drug Name and Price	Lovastatin ($24.04)	Mevacor ($79.10)
Copayment	$3.61 (15% of $24.04)	$19.78 (25% of $79.10)
Price difference between brand-name and generic	Not applicable	$55.06 ($79.10 - $24.04)
Member's Total Cost	**$3.61**	**$74.84** ($19.78 + $55.06)
Extra cost for member to purchase brand-name drug = $71.23 ($74.84 - $3.61)		

If Al had elected to use the generic alternative, Lovastatin, his copayment would have been 15% of the $24.04 price of the generic drug, or $3.61. However, because he chooses to purchase the brand-name drug (Mevacor) when a generic is available, his copayment will be 25% of the higher price for the brand-name drug, or $19.78. In addition to this copayment, he must pay the full difference in price between the brand name and generic ($79.10 - $24.04 = $55.06). In total, Al must pay $74.84 for the brand-name prescription (copay of $19.78 plus the brand-generic price difference of $55.06). By purchasing the generic version, Al could have saved $71.23.

Certain brand-name drugs will not be subject to the "pay the difference" penalty. These brand-name drugs are on Medco Health's Narrow Therapeutic List. Only the 25% brand copayment will apply to these brand-name prescription drugs. The list, which is subject to change, now includes:

- Clozaril (clozapine)
- Coumadin (warfarin)
- Depakene (valproic acid)
- Branded digoxin (e.g. Lanoxin)
- Dilantin (phenytoin)
- Branded levothyroxine (e.g. Synthroid, Levothroid)
- Mysoline (primidone)
- Neoral (cyclosporine)
- Tegretol (carbamazepine)
- All sustained-released theophyllines

Any questions about the Narrow Therapeutic List can be directed to Medco Health on 1-800-718-6590.

Prescription Drug Plan
(Administered by Medco Health)

The chart below summarizes the outpatient drug benefits available to members of medical plans administered by UnitedHealthcare.

Prescription Drug Benefits for UnitedHealthcare Plan Members (Administered by Medco Health)	
Provisions	**NAP and CAP**
Retail Drug Purchases	First three 30-day supplies at a participating pharmacy: 85% for generic drugs, 75% for brand-name drugs. For refills beyond 90 days and coverage at non-participating pharmacies: 80% for generics and 70% for brand-name drugs. **Generic Incentive Provision applies (see below).**
Home Delivery (Mail-Order) Purchases	90% for generic drugs and 80% for brand-name drugs. **Generic Incentive Provision applies (see below).**
Deductible	No deductible
Out-of-Pocket Maximum	$500 per person, $1,000 per family. Out-of-pocket maximum covers both the retail drug plan and the home delivery drug plan (does not coordinate with medical plan).
Fertility, Sexual Dysfunction, Memory Enhancement and Birth Control Drugs	50% for both retail and home delivery plans, unless medically necessary. Medically necessary drugs are covered at standard reimbursement rates. **Generic Incentive Provision applies (see below).**
Lifetime Maximum	None
Generic Incentive Provision	Member is responsible for paying the difference between the price of a generic prescription drug and a brand-name prescription drug, plus coinsurance, if purchasing a brand-name drug when a generic is available.

Mental Health, Alcohol and Drug Care Benefits

Members in UnitedHealthcare Plans receive mental health benefits through the Mental Health, Alcohol and Drug Care Program administered by ValueOptions. Effective January 1, 2004, the copayment for outpatient mental health visits received through this program is increasing from $10 to $15 per visit. Another change is that there will be no charge for the initial visit to a psychiatrist (M.D.) for medication evaluation.

Members in HMOs receive mental health benefits through their HMOs. Most of the HMOs are raising copayments for mental health visits. The new copayments for HMO services will be specified on the comparison charts included with your Open Enrollment information.

Beginning July 1, 2003, Kaiser members – with pre-approval by ValueOptions or an Employee Assistance Program (EAP) counselor – are eligible to receive inpatient or residential treatment for alcohol and drug abuse through the Mental Health, Alcohol and Drug Care Program. (Previously, inpatient benefits were limited to treatment for medical detoxification through Kaiser only). Kaiser members will continue to receive outpatient alcohol and drug care coverage through Kaiser.

PacifiCare and Health Net members currently receive alcohol and drug care benefits through the program administered through ValueOptions and also through their HMOs. In 2004, these benefits will only be available through the ValueOptions program, not through PacifiCare or Health Net.

The following chart summarizes how mental health, alcohol and drug care benefits will be provided for each medical plan in 2004.

Medical Plan You're Enrolled In:	Mental Health Benefits Provided By:	Alcohol and Drug Care Benefits Provided By:
Plans Administered by UnitedHealthcare		
Network Access Plan (NAP)	ValueOptions (VO)	ValueOptions (VO)
Comprehensive Access Plan (CAP)	ValueOptions (VO)	ValueOptions (VO)
Health Maintenance Organizations (HMOs)		
Health Net	Health Net	ValueOptions (VO)
Kaiser Permanente – North	Kaiser Permanente – North	- Outpatient through Kaiser - Inpatient & Residential through ValueOptions (VO)
Kaiser Permanente – South	Kaiser Permanente – South	- Outpatient through Kaiser - Inpatient & Residential through ValueOptions (VO)
PacifiCare	PacifiCare	ValueOptions (VO)

Employee Assistance Program

In 2004, the number of visits to an Employee Assistance Program (EAP) counselor per case will increase from three to six. There is no charge to employees for these visits.

Retiree Medical Benefits

Retirees Can Drop Coverage and Re-Enroll at a Later Date

Retirees who drop their PG&E medical coverage on or after January 1, 2003, will be allowed to re-enroll during future Open Enrollment periods. Retirees will be responsible for notifying the HR Service Center by September 1st if they wish to re-enroll for the next year.

Retirees who dropped PG&E retiree medical plan coverage prior to January 1, 2003, and surviving dependents who drop coverage at any time are not eligible to re-enroll.

Eligibility Changes for Coverage & Company Contribution

Employees must be at least age fifty-five when they retire to be eligible for medical plan coverage as a retiree. ***Effective January 1, 2004, employees must have a minimum of ten years of service to be eligible for retiree medical plan coverage and to receive a Company contribution toward their monthly medical plan premium.*** In addition, the amount the Company contributes will be prorated for both retirees under age 65 and retirees over age 65, based on years of credited service. Each year of credited service will qualify a retiree to receive 4% of the full Company contribution. Those with 25 years or more of service will receive 100% of the fixed maximum amount the Company contributes.

New Benefit – Retiree Premium Offset Account

Effective January 1, 2004, a new benefit – the Retiree Premium Offset Account – will be available to retirees who qualify. Current and future retirees with more than ten years of credited service at retirement will be eligible for the account, provided they are eligible to enroll in a PG&E medical plan. The account can be used to pay 50% of their PG&E monthly medical plan

premiums. The Company will contribute up to $500 per year for credited service beyond ten years, up to a lifetime maximum account balance of $7,500.

Example:

Barry retires with 22 years and 11 months of credited service. The calculation for his Retiree Premium Offset Account will take into account his years of credited service beyond ten years, multiplied by $500 per year. On a monthly basis, the $500 per year equates to $41.6666 per month.

Barry has 22 years and 11 months of credited service, so his credited service beyond ten years is 12 years and 11 months. Therefore, the formula for calculating his account balance is as follows:

12 years and 11 months = 155 months x $41.6666 = $6,458

Thus, Barry's account balance is $6,458. He can use this account to pay 50% of his medical premiums each month.

NOTES

WHERE TO GET HELP

Topic	Contact	Phone Number
Questions About Enrollment or Benefits	PG&E HR Service Center	Co. Ext. 223.2363, 415.973.2363, or 1.800.788.2363
	E-Mail Address	HRBenefitsQuestions@pge.com
	HR Web Site	wwwhr

MEMBER SERVICES NUMBERS

For information or provider directories, call the appropriate plan's number listed below.

Plan	Phone Number	Web Site
Dental Plan	1.888.217.5323	www.deltadentalca.org
Employee Assistance Program	1.888.445.4436	wwwhr/benefits
Health Net	1.800.522.0088	www.health.net
Kaiser Permanente (North and South)	1.800.464.4000	www.kaiserpermanente.org
PacifiCare	1.800.624.8822	www.phs.com
PG&E Medical Plans (Administered by United Healthcare) - Network Access Plan (NAP) - Comprehensive Access Plan (CAP)	1.877.842.4743	www.provider.uhc.com/pge - or - www.myuhc.com
American Specialty Health Network	1.800.678.9133	www.ashplans.com
Cancer Resource Services	1.866.936.6002	www.urncrs.com
Mental Health, Alcohol and Drug Care Program (Administered by ValueOptions)	1.800.562.3588	www.valueoptions.com
Prescription Drug Plan (Administered by Medco Health)	1.800.718.6590	www.medcohealth.com
Reimbursement Accounts (Administered by UnitedHealthcare)	1.877.842.4743	www.myuhc.com
Vision Plan (Administered by Vision Service Plan)	1.800.877.7195	www.vsp.com