Pacific Gas and Electric Company®

Medical Care 2006

ENROLLMENT GUIDE

for Retirees and Surviving Dependents

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. Descriptions of these plans do not include the important legal definitions or limitations that are in plan documents or HMO contracts governing your benefits. Therefore, this booklet does not replace those legal documents, and in case of conflict, those legal documents govern your benefits. Since future conditions affecting the company cannot be foreseen, the company reserves the right to amend or terminate the plans at any time, subject to notice provisions required under applicable collective bargaining agreements. 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 Our Retirees

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

This year's retiree Open Enrollment kicks off on the day PG&E celebrates its 100-year anniversary. While we celebrate the company's history, we are looking forward to the future and positioning PG&E for the next 100 years.

This enrollment guide provides detailed information about the 2006 enrollment process and plan changes. We're offering a new medical plan administrator aimed at increasing service levels and lowering premium cost increases. You may have heard about the government's new Medicare Part D prescription drug benefit, which is good news for retirees on Medicare who choose to remain in PG&E-sponsored medical plans. Be sure to read the *Understanding Medicare Part D* booklet provided in your enrollment packet for details.

You have important decisions to make and a variety of options from which to choose. That's why it's important that you take an active part in the enrollment process and choose the best plan for your personal situation. Your enrollment materials provide tips on how you can save money on your health care-related expenses. Look for the "Hot Tip" boxes throughout this guide.

We're here to help, so if you have any questions about your medical plan options, please feel free to contact the HR Service Center at hrbenefitsquestions@pge.com, or by calling 415-972-7077 or 800-700-0057.

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 retiree or covered dependent, 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. First, the company is switching the administration of the self-funded medical plans (NAP, CAP, ROP and MSP) from UnitedHealthcare to Blue Cross of California. This change will result in lower premium increases for these four plans in 2006.

Also in 2006, the government is launching a new Medicare Part D prescription drug benefit. Since PG&E already offers drug coverage to its members, the government is providing a financial incentive, or subsidy, to the company for continuing to offer it. PG&E is passing all of the company's net savings of the subsidy on to its 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 and the *Understanding Medicare Part D* booklet included in your enrollment packet.

Take Charge of Your Health-Care Decisions

While PG&E is working hard to help keep your medical plan costs as low as possible, the company needs your help. One of the most important things that you 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 each year to make sure you are selecting the best option.

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 dependents **(remember, the HMO options have no deductibles to meet)**
- 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
- Home health, skilled nursing facility and hospice care
- Outpatient physical therapy visits
- Mental health and substance abuse treatment.

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

If your medications are not covered by your 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 name-brand equivalents.

How will my Medicare eligibility and/or that of my covered dependents affect my choice of plans?

Medicare-eligible participants have several plans to choose from and each coordinates with Medicare in different ways. Review pages 23 to 26 for details on the differences between these plans.

As explained further in the *Understanding Medicare Part D* enrollment packet booklet, you should also look at how the federal government's new Medicare Part D prescription drug benefit may affect your various PG&E-sponsored medical plan options.

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

The monthly premium contributions for each plan available to you are shown on your 2006 Enrollment Worksheet. HMO premiums 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. In addition to the HMOs, many retirees also find the Retiree Optional Plan or the Medicare Supplemental Plan to be more cost-effective alternatives.

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

Call the medical plan's member services number or visit its Web site to find out which medical plans your doctor contracts with (see outside back cover).

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. If you plot out your anticipated needs throughout the year and then weigh them against how much your monthly premiums, copayments and deductibles will cost for each option, that will give 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 **Monday, October 10, 2005, and ends on Friday, October 21, 2005**. During this time, you'll have the opportunity to make changes to your PG&E medical plan coverage to ensure you have the best medical plan for your individual needs. 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 medical plan benefits. Use this information to help you make decisions regarding your medical coverage for 2006.

Who Needs to Enroll?

If you plan to make **any** changes to your medical coverage in 2006, you must enroll. However, if you're not planning to make any changes to your medical coverage, you may not need to do anything at all. Just be sure to review the following:

- Your current medical plan's availability and monthly cost for 2006, as shown on your Enrollment Worksheet
- Your dependents' eligibility (see pages 17-20)
- "What's New for 2006" (see pages 5-7)
- *Understanding Medicare Part D* — If you or your dependents are Medicare-eligible or will become Medicare-eligible during 2006, you need to read this booklet (which is included in your enrollment packet) to determine if you need to enroll.
- Plan changes (indicated in bold on the Comparison of Benefits charts that begin on page 28)

Taking these easy steps will help you decide whether your current medical coverage, or a different one, is the best plan for you!

PG&E HR SERVICE CENTER:

415-972-7077 or 800-700-0057

IMPORTANT

The 2006 Open Enrollment period begins **Monday, October 10, 2005**, and ends **Friday, October 21, 2005**.

What's NEW for 2006

Medicare Part D Prescription Drug Coverage

Beginning January 1, 2006, the Medicare program is adding a prescription drug benefit called Medicare Part D. If you, or any of your dependents, are on Medicare or become eligible for Medicare in 2006, it's very important that you read the *Understanding Medicare Part D* booklet included in your enrollment packet so that you know how this new Medicare program affects your PG&E medical plan coverage.

Blue Cross Replaces UnitedHealthcare

As recently announced to retirees, 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), the Retiree Optional Plan (ROP) and the Medicare Supplemental Plan (MSP).

Why Is PG&E Making This 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 2006 rate increases will be smaller. In addition, Blue Cross has a track record of providing great service. This means faster and more accurate claims processing and overall better 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.

The company's three employee unions have reviewed the selection of Blue Cross and support this change. Given Blue Cross of California's reputation for quality and customer service, we believe this will be a positive change for retirees, 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 plans' covered services, copayments, coinsurance and deductibles for the plans 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 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

Please note that the new Blue Cross plan administrator should not be confused with the Blue Shield HMO plan, which PG&E introduced to its members beginning in 2005.

(continued on next page)

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 CAP, the ROP and the MSP can use any doctor they want, although members not on Medicare 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 members at PG&E a welcome packet, explaining important information regarding claims procedures, medical management and disease management services.

What You Need to Do

If you're currently enrolled in a UnitedHealthcare-administered plan (NAP, CAP, ROP or MSP), 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.

MSP Member Alert

If you are currently enrolled in the PG&E Medicare Supplemental Plan (MSP), you have a $10,000 lifetime maximum on medical benefits that the plan will pay (excluding what Medicare pays), as well as a separate $10,000 lifetime maximum on prescription drug benefits received through Medco Health. Be sure to take into consideration how close you are to reaching these two $10,000 benefit caps before remaining enrolled in the MSP. If you reach either $10,000 lifetime maximum benefit during 2006, the applicable plan will not pay additional benefits, and you will not be allowed to change plans until the next Open Enrollment period.

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 do so before the end of the year, your domestic partner medical coverage will be terminated effective January 1, 2006. Contact the HR Service Center at 415-972-7077 or 800-700-0057 to request a list of current municipalities that offer a domestic partner registry.

HMO Changes

PacifiCare Acquired by UnitedHealthcare

You may have heard that UnitedHealthcare is purchasing the PacifiCare HMO and its Secure Horizon Medicare HMO. PG&E has been informed that there will not be any operational changes to PacifiCare or Secure Horizons for 2006 as a result of UnitedHealthcare's acquisition, and that the HMO's networks and benefits will continue with uninterrupted service. For additional information about PacifiCare or Secure Horizons, please call the HMO directly at the appropriate 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 presented here is current as of its publication date (September 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.

What You Need to Do for
OPEN ENROLLMENT

Five Easy Steps

1 **Review your enclosed personalized 2006 Enrollment Worksheet.** The worksheet shows the plan in which you are currently enrolled (if it is still available), the medical plan options available to you for next year and the 2006 premiums for each of your plan options. If you have a Retiree Premium Offset Account (RPOA), please refer to your most recent pension pay stub for your current account balance. You can use this information to estimate what your remaining RPOA balance will be on January 1.

2 **Review your dependents' eligibility** (see pages 18 to 20 for eligibility rules). If you have a dependent who is no longer eligible for coverage, be sure to remove the dependent from your medical plan 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" form. 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 guide,** including the Comparison of Benefits charts and the 2006 Medical Plan Monthly Premium Contributions sections. **If you or any of your dependents are eligible for Medicare, you also need to read the *Understanding Medicare Part D* booklet included in your Open Enrollment packet.**

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

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

- select a new medical plan, i.e., 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, or
- start or stop using a Retiree Premium Offset Account (if eligible).

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

You **may not need to enroll** if you:

- want to keep the same medical plan and you have verified that the plan is still available in your area **OR** your current medical plan will no longer be offered in 2006 and you want to be automatically switched to the appropriate Blue Cross-administered plan for which you are eligible (NAP or CAP), as shown on your Enrollment Worksheet
- do not need to add or delete any dependents, and
- will not be changing your Retiree Premium Offset Account election in 2006.

5 **To make changes, call the HR Service Center at 415-972-7077 or 800-700-0057** between the hours of 7:30 a.m. and 5:30 p.m. Pacific Standard Time, Monday through Friday, during the Open Enrollment period.

Within 10 days of enrolling, you will receive a confirmation statement showing your changes, which will be effective January 1, 2006. See "After You Enroll" on page 11 for additional information.

HOT Tip

If you have a Retiree Premium Offset Account (RPOA), review your most recent pension pay stub to estimate what your current balance will be on January 1. If your account balance is likely to be exhausted during 2006, you should take this into consideration when you enroll. **You won't be allowed to switch to a less expensive medical plan in the middle of the year if your RPOA balance becomes depleted.**

HOT Tip

Don't forget about the Retiree Premium Offset Account (RPOA). If eligible, you can use it to pay 50 percent of your PG&E monthly medical premium contributions. See the RPOA section on page 13 of this guide for more details.

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 enrollment material, including the Enrollment Guide, the *Understanding Medicare Part D* booklet (if applicable) and your Confirmation Statement
- acknowledge that you have received the Notice of Creditable Coverage included at the end of the *Understanding Medicare Part D* booklet
- 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 premium contributions from your pension check, if applicable, or to bill you if your pension check is not sufficient
- 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 you will not be able to change medical plans during 2006 if your RPOA balance becomes depleted
- 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
- acknowledge that you understand your PG&E medical and prescription drug coverage will be cancelled if you enroll in a Prescription Drug Plan outside of the PG&E enrollment process
- agree to call the HR Service Center to report any ineligible dependents within 31 days of a dependent's loss of eligibility.

IMPORTANT

Whether or not you make any changes to your coverage, you should review your confirmation statement carefully to ensure it is accurate. If there is an error, call the HR Service Center immediately at 415-972-7077 or 800-700-0057.

NOTE: All changes must be made by calling the HR Service Center.

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, ROP or MSP plans. However, all of the HMOs and Medicare 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 want 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 7. 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." (NOTE: Surviving dependents are not eligible for domestic partner benefits.)

HOT Tip

All eligible retirees and their covered dependents should enroll in Medicare Parts A and B as soon as they become eligible. If you are under 65 and disabled, you can request assistance with enrolling in Social Security through Allsup, a company that has been contracted by PG&E to help you (see page 16).

Medicare Part D works differently than Parts A and B. Please read the special *Understanding Medicare Part D* booklet included in your enrollment packet.

After
YOU ENROLL

Making Changes After Open Enrollment

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

- You have an eligible change-in-status event (see page 21)
- You move out of your HMO's service territory
- You want to disenroll from a Medicare HMO (see page 25)

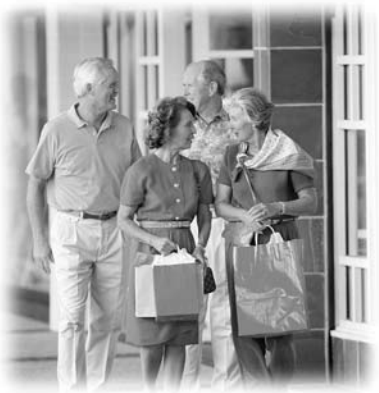
- or -

- You or your dependent becomes eligible for Medicare/Medicaid.

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 2006, you will not be able to change medical plans. Instead, you will need to obtain services from a participating 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

If you make changes during Open Enrollment, you will receive a confirmation statement showing your 2006 medical coverage, your retiree premium contributions and, if applicable, your Retiree Premium Offset Account election within 10 days . If you don't make any changes, you will receive a confirmation statement verifying your continued coverage by December 31, 2005.



HOT Tip

Adopt a healthy lifestyle to avoid illness. Take advantage of special health programs offered by your medical plan, such as smoking cessation programs, weight management classes and stress management clinics.

Membership Identification Cards

If you change medical plans or add dependents, you'll receive your new medical plan identification card(s) in January 2006. 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 card off of Blue Cross' custom Web site for PG&E members at www.bluecrossca.com/clients/pge.

In addition, Medicare members in many plans will receive new ID cards even if they remain in the same plans.

Medical Plan

PREMIUM CONTRIBUTIONS

Surviving Dependent Contributions

Surviving Dependents pay the full cost of their required medical plan premiums, as the company does not make any baseline contributions towards the cost. In addition, most surviving dependents are not eligible for a Retiree Premium Offset Account (RPOA). However, members who became surviving dependents on or after January 1, 2004, may be eligible to "inherit" an RPOA balance, if the employee or retiree was or would have been eligible for the account and the account has not been depleted.

Retiree Contributions

If you qualify for PG&E retiree medical plan coverage, the company contributes a fixed amount towards the cost of your coverage. This baseline amount is prorated for certain retirees with less than 25 years of service.

You are responsible for paying the remaining portion of the medical plan premium that is above the fixed dollar amount the company contributes. However, if you are eligible for a Retiree Premium Offset Account (see page 13), you may draw upon the account to offset 50 percent of the amount that you pay towards your 2006 monthly medical plan coverage, as indicated on your 2006 Enrollment Worksheet.

Baseline Company Contributions

The baseline amount the company contributes each month for your medical plan coverage is based on your age, the age of your spouse or domestic partner (if applicable), whether or not you are covering any children and your years of credited service. The Retiree Premium Offset Account (RPOA) is an additional contribution made by the company to members who qualify for the account (see page 13).

For retirees under age 65, the company's baseline contribution is based on the premium costs for under-65 members of the company's self-funded network medical plan that existed in the year 2000. For retirees age 65 and over, the company's baseline contribution

Fixed Maximum Baseline Monthly Company Contribution *For Retirees Under Age 65 with 25 or More Years of Service**	
Retiree Only	$262.91
Retiree + Spouse/Domestic Partner under 65	$553.14
Retiree + Spouse/Domestic Partner over 65	$429.75
Retiree + Children	$474.44
Retiree + Family (Spouse/Domestic Partner under 65)	$765.03
Retiree + Family (Spouse/Domestic Partner over 65)	$692.88

**For retirees with less than 25 years of service, these contribution amounts will be prorated based on your years of credited service (see page 13).*

Fixed Maximum Baseline Monthly Company Contribution *For Retirees Over Age 65 with 25 or More Years of Service**	
Retiree Only	$87.07
Retiree + Spouse/Domestic Partner under 65	$174.14
Retiree + Spouse/Domestic Partner over 65	$174.14
Retiree + Children	$174.14
Retiree + Family (Spouse/Domestic Partner under 65)	$261.21
Retiree + Family (Spouse/Domestic Partner over 65)	$261.21

**For retirees who retired after 2003 with less than 25 years of service, these contribution amounts will be prorated based on your years of credited service (see page 13).*

is based on the year 2000 premium for the PG&E Medicare Supplemental Plan (MSP). These contribution amounts are fixed and will not change over time.

Maximum Baseline Contribution: All retirees with 25 years of credited service or more qualify to receive 100 percent of the company's fixed maximum baseline contribution. The full baseline amounts of the company contribution are shown on page 12.

Prorated Baseline Contribution: Your baseline company contribution is prorated if:

- you are under age 65 and you retired with less than 25 years of credited service, or
- you are over age 65 and you retired **after 2003** with less than 25 years of service.

Each full year of credited service qualifies you to receive four percent of the baseline company contribution shown on page 12. In addition, any remaining fractional year of credited service qualifies you to receive a prorated portion of another four percent of the baseline contribution.

Retiree Premium Offset Account (RPOA)

The RPOA benefit was introduced in 2004 to help eligible retirees partially defray the cost of their monthly PG&E medical plan contributions. The RPOA is a one-time allotment of "notional" funds the company provides to you to offset 50 percent of your monthly medical plan premium contributions. Retirees with more than 10 years of credited service at retirement are eligible for the account.

The RPOA is not a medical plan, nor does it have any actual cash value. Rather, it is a hypothetical account that contains "credits" which can be used to help finance the amount you must pay when you participate in a PG&E-sponsored medical plan. The RPOA is 100 percent funded by the company, costing you nothing out of your own pocket to fund or use.

The amount of your one-time RPOA allotment depends on how many years of credited service you had upon retirement. The company contributes up to $500 for each year of credited service beyond your first 10 years of service. Retirees with 25 years or more of credited service qualify for the maximum allotment of $7,500.

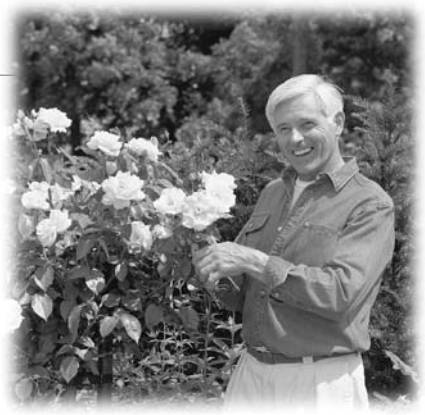
Each year during Open Enrollment, if you have a positive RPOA balance, you will have the opportunity to decide if you want to either start, stop or continue using your RPOA balance to pay 50 percent of your monthly PG&E medical plan premium contributions for the upcoming calendar year. If you don't call the HR Service Center during Open Enrollment to make changes for the upcoming year, your current RPOA election (i.e., to use or not use the account) will remain the same.

After the Open Enrollment period ends, you cannot change your RPOA election unless you have an eligible mid-year change in status (see page 21). If your account balance becomes depleted at any point during the year, you will be responsible for paying the full medical plan premium contribution for your current medical plan at that time through the end of the year. **You will not be allowed to switch to a less expensive medical plan during the year if you exhaust your RPOA balance.**

Please note that you cannot use a Retiree Premium Offset Account unless you are actively enrolled in a PG&E medical plan.

HOT *Tip*

One strategy to manage costs is to select the Retiree Optional Plan (ROP). The ROP has lower monthly premiums than the NAP and the CAP plans. Although the ROP provides lower benefits than other plans for services rendered, it still provides substantial benefits in the event of a major illness. See page 24 for more information.



(continued on next page)

Calculating Your Retiree Medical Premium Contributions

Your monthly premium contribution is the difference between the actual (full) cost of the plan in which you're enrolled and the amount the company contributes. Since the actual cost of most medical plans in 2006 is more than the amount the company contributes, members of most plans will be required to make a monthly contribution towards the premium. However, if you have an RPOA balance as described on page 13, you may draw upon the account to reduce your monthly premium contribution by 50 percent. Here are a few examples to show how your monthly contribution amount is calculated — both with and without the RPOA election:

Sample 2006 Monthly Premium Calculations

Retiree + Spouse

Retiree and Spouse Both Over Age 65 in CAP Plan

	2006 Monthly Cost for CAP Plan — Retiree + Spouse Over 65	$615.34
Minus	Baseline Company Contribution for Retiree + Spouse Both Over 65	– $174.14
	Your Monthly Premium Contribution (without RPOA)	**= $441.20**
Minus	50% if RPOA Elected	– $220.60
	Your Monthly Premium Contribution (with RPOA)	**= $220.60**

Retiree Over Age 65 in CAP Plan and Spouse Under Age 65 in NAP Plan*

	2006 Monthly Cost for CAP Plan — Retiree Over 65 + Spouse Under 65	$857.23
Minus	Baseline Company Contribution for Retiree Over 65 + Spouse Under 65	– $174.14
	Your Monthly Premium Contribution (without RPOA)	**$683.09**
Minus	50% if RPOA Elected	– $341.55
	Your Monthly Premium Contribution (with RPOA)	**$341.54**

Retiree Over Age 65 in Health Net Seniority Plus and Spouse Under Age 65 in Health Net HMO*

	2006 Monthly Cost for Health Net Seniority Plus — Retiree Over 65 + Spouse Under 65	$632.57
Minus	Baseline Company Contribution for Retiree Over 65 + Spouse Under 65	– $174.14
	Your Monthly Premium Contribution (without RPOA)	**$458.43**
Minus	50% if RPOA Elected	– $229.22
	Your Monthly Premium Contribution (with RPOA)	**$229.21**

**If an individual is under 65 but receiving Medicare, the plan's cost will be less; however, the company's contribution will remain the same.*

If you are a retiree over age 65, you will notice that the cost of covering a spouse or domestic partner who is under age 65 may be significantly higher than the cost of covering a Medicare-eligible spouse/domestic partner. This is because the company's baseline contribution for retirees over age 65 is based solely on the age of the retiree, but the cost of the medical plan is based on the Medicare statuses of both the retiree and the spouse/domestic partner. Premiums are higher for spouses/domestic partners who are not eligible for Medicare, but the company's contribution is the same, resulting in a higher cost for you.

Why Do Premiums Increase So Much From Year To Year?

The large percentage increase of retiree medical plan premiums is due to ever-increasing medical plan premiums (see "Health Care Costs Continue to Rise" on page 2). However, due to cost-saving measures recently taken by the company (see "PG&E Makes Cost-Saving Changes"also on page 2), some of the monthly premiums for PG&E-sponsored retiree medical coverage will actually be going down in 2006 for the first time in years.

So why are rates for some plans still going up this year? In short, any increase in premiums can be attributed to the impact of the company's frozen contribution. Retirees absorb the entire cost of medical plan premium increases, since the company's baseline contribution remains constant.

Changing to Blue Cross of California allowed PG&E to keep the 2006 premium increases lower for the NAP, CAP, ROP and MSP plans. In some instances, the premiums have even gone down!

The chart below illustrates the impact of the company's frozen contribution on premium increase. This example shows a retiree under age 65 currently enrolled with a spouse (also under age 65) in the NAP plan. The monthly premium contribution is currently $441.37, with the company picking up the other $553.14 of the total $994.51 cost for coverage. For 2006, the total cost for coverage in the NAP plan is $1049.15, which is 5.5 percent more than the full cost for the NAP plan for 2005. However, because the retiree must pick up the entire cost of this increase, the retiree's share of the cost will go up $54.64 (from $441.37 to $496.01), with the company's contribution staying fixed at $553.14. This represents a 12.4 percent increase over the retiree's current premium.

NAP Monthly Plan Costs for Retiree* + Spouse Both Under Age 65

	2005 NAP Plan	2006 NAP Plan	% Increase
Total Monthly Cost	$ 994.51	$ 1049.15	5.5%
Company Contribution	– $ 553.14 (frozen)	– $ 553.14 (frozen)	N/A
Your Monthly Cost (without RPOA)	$ 441.37	$ 496.01	12.4%

**Assumes retiree with 25 years of credited service or more*

HOT Tip

PG&E offers several HMO plans that cost less than the NAP and CAP plans. HMO coverage is limited to certain geographical locations within California, so you'll need to check your 2006 Enrollment Worksheet to see which HMOs, if any, are offered where you live.

Other

IMPORTANT INFORMATION

Medicare Part B Reimbursement for Disabled Retirees Under Age 65

In 2006, the company will continue to reimburse the full Medicare Part B premium to eligible disabled retirees and any of their disabled dependents who are under age 65 and who qualify for Social Security. If you are a retiree under age 65 and believe you or any of your dependents may qualify for Social Security due to a disability, please contact Allsup, Inc. at 888-339-0743. The company contracts with Allsup, Inc. to provide Social Security enrollment assistance, at no cost, to potentially qualifying disabled retirees. Once enrolled in Medicare, you are required to provide PG&E with a copy of your Medicare card.

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, coverage will be provided in a manner determined in consultation with the attending physician and the patient for the following:

- reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance
- 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 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
- Learn about health and wellness topics, such as fitness, nutrition and disease management.

Eligibility

Retirees

Employees Who Retired Prior To 2004

If you retired prior to January 1, 2004, you are automatically eligible for PG&E retiree medical plan coverage, unless you dropped coverage prior to January 1, 2003. (Note: Retirees who dropped coverage prior to 2003 are not eligible to re-enroll for PG&E medical coverage at any time.) In addition, if you had 10 or more years of credited service at retirement, you are eligible for a one-time allotment to a Retiree Premium Offset Account (see page 13).

Employees Who Retired In 2004 or Later

Bargaining unit employees who retired January 1, 2004, or later, and all Flex Plan employees who were hired January 1, 2004, or later must have at least 10 years of credited service upon retirement to be eligible for PG&E retiree medical plan coverage and a one-time allotment to a Retiree Premium Offset Account (RPOA).

Flex Plan employees who were hired prior to January 1, 2004, are automatically eligible for PG&E retiree medical plan coverage upon retirement, regardless of years of service. However, a minimum of 10 years of credited service is required to qualify for the one-time RPOA allotment.

If you drop PG&E retiree medical plan coverage during Open Enrollment, you must wait for a subsequent Open Enrollment period to re-enroll, as described below.

Re-Enrolling After Cancellation

Retirees who cancel medical plan coverage on or after January 1, 2003, will be allowed to re-enroll in a PG&E-sponsored medical plan during any subsequent Open Enrollment period. To initiate re-enrollment, **you must call the HR Service Center to request an Open Enrollment packet no later than September 1** of the year prior to the year for which you want to re-enroll. An enrollment packet will be mailed to your home immediately prior to Open Enrollment. Any coverage you elect during Open Enrollment will be effective the following January 1.

If you do not notify the HR Service Center by September 1, you will not be able to re-enroll for the upcoming year.

Please note that retirees who dropped PG&E retiree medical plan coverage prior to January 1, 2003, are not eligible to re-enroll for PG&E medical plan coverage.

Non-Payment of Premiums

If you do not pay your medical plan premiums, your coverage will be cancelled and you will not be able to re-enroll in a PG&E-sponsored medical plan again.

Surviving Dependents

As a surviving dependent (spouse, domestic partner or eligible dependent child) of a company employee or retiree, you are eligible for continued medical plan coverage if you were enrolled in a company-sponsored medical plan at the time of the employee's or retiree's death and you are not covered under another group plan (other than Medicare). **If you are a surviving dependent child**, you must also meet other eligibility criteria (see **Eligibility** on page B-3 of your *Summary of Benefits Handbook*).

If You Get Married

Surviving dependents who get married are no longer eligible to be covered under a PG&E-sponsored medical plan, even if the new spouse has no other medical coverage. If you get married, please notify the HR Service Center immediately to avoid penalties.

Cancellation

Surviving dependents who cancel medical plan coverage will not be able to enroll in a PG&E-sponsored medical plan again at any time in the future.

(continued on next page)

Premiums

Surviving dependents pay the full cost of their required medical plan premiums, as the company does not make any baseline contributions towards the cost. See page 12 for additional information.

Non-Payment of Premiums

If you do not pay your medical plan premiums, your coverage will be cancelled and you will not be able to re-enroll in a PG&E-sponsored medical plan again.

Dependents of Members

Eligible Dependents

You may also enroll your eligible dependents in the company-sponsored medical plans. Eligible dependents include:

- Your legally married spouse or registered domestic partner; note that surviving dependents are not eligible for domestic partner benefits (see page 7 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 (for retirees only); does not include the legal wards of your domestic partner
- Your unmarried, dependent children age 19 through 23 who meet the IRS definition of an eligible dependent, whether or not you claim them as dependents on your income tax returns; retirees may also cover a registered domestic partner's children who meet the IRS criteria

- 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** on page B-4 of 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 415-972-7077 or 800-700-0057 to drop any ineligible dependents.

Domestic Partner Tax Certification

If you are covering a domestic partner and/or the child(ren) of a domestic partner, you must re-certify their tax dependency each year. If you don't receive a "Certification of Tax Dependency for Domestic Partnerships" form for the upcoming tax year, please request a form by calling the HR Service Center at 415-972-7077 or 800-700-0057. 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 medical plan, 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 medical plan premiums 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, as such, will continue to be considered an eligible tax dependent for purposes of medical 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 medical plan within 31 days should your registered domestic partnership legally come to an end.

IMPORTANT

Remember, it is your responsibility to ensure that 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. Members who cover ineligible dependents will be required to make restitution to the company, up to a maximum of $7,500. Members who refuse to make restitution or who default on an agreement to repay the company will be subject to permanent cancellation of medical plan coverage through Pacific Gas and Electric Company.

To drop ineligible dependents, call the HR Service Center at 415-972-7077 or 800-700-0057.

(continued on next page)

Ineligible Dependents

Ineligible dependents include, but are not limited to:

- A legally separated, divorced or common-law spouse, even if a court orders you to provide medical coverage
- A domestic partner who has not been formally registered with a valid registry; or a former domestic partner (see page 7 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 you have adopted them or have been appointed permanent legal guardianship by a court
- Children age 19 through 23 who do not meet the current IRS definition of an eligible dependent
- Children age 24 and over, unless they have been approved for continued coverage under the disabled dependent provision
- Your disabled dependents if they have not been certified as disabled by a physician before they would otherwise cease to qualify as a dependent, 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 company/PG&E Corporation employee or retiree
- Grandchildren, nieces, nephews or other family members, unless you have legally adopted them or have been appointed permanent legal guardianship by a court

- or -

- A family member or domestic partner who is a company/PG&E Corporation employee or retiree who has his or her own coverage through PG&E.

IMPORTANT

If your spouse/registered domestic partner is also a PG&E Utility or PG&E Corporation employee or retiree, only one of you may enroll each child as an eligible family member under any one benefit plan. In addition, you cannot cover your spouse/registered domestic partner if he or she has their own PG&E-sponsored health coverage or is eligible for Flex Benefits.

Change-In-Status
EVENTS

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, as listed below. If you're not currently enrolled in a PG&E-sponsored medical plan, these change-in-status events do not apply.

Any changes that you request typically must be consistent with your change-in-status event. For example, if you're a retiree and you get married, you may add your new spouse and stepchildren (if any). However, you cannot change medical plans. Similar rules apply to making changes to your election to use or not use a Retiree Premium Offset Account; mid-year changes will only be allowed if they are consistent with your change-in-status event. For more details, refer to your *Summary of Benefits Handbook* or call the HR Service Center at 415-972-7077 or 800-700-0057.

PLEASE NOTE: The withdrawal of a provider, i.e., doctor, medical group, hospital, etc. from your plan's network — or the fact that a provider you want to use 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 your medical plan during the year if your desired provider does not contract with your plan.

Eligible Change-in-Status Events

The following change-in-status events are only applicable to participants currently enrolled in a medical plan:

- Marriage or the establishment of a registered domestic partnership (retirees only)
- Dissolution of marriage (including final divorce or annulment), legal separation or termination of a domestic partnership; note that you cannot cover your ex-spouse on your company-sponsored medical plan, even if a court orders you to provide coverage
- Retiree or dependent becoming Medicare- or Medicaid-eligible
- The birth or adoption of a child, or your court-ordered appointment of permanent legal guardianship for a child

IMPORTANT

Call the HR Service Center within 31 days of any eligible change-in-status event (60 days for births and adoptions) if you need to make enrollment changes. Otherwise, you may not be able to add any dependents until the next Open Enrollment period.

HR Service Center
415-972-7077 or 800-700-0057

- A change in your spouse's/registered domestic partner's or dependent's employment that results in a gain or loss of medical plan coverage
- A change to or from full-time or part-time employment by your spouse/registered domestic partner or dependent(s), if medical plan eligibility is affected
- An unpaid leave of absence taken by 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.

If You Move Out of HMO Service Area

If you move out of your HMO's service area, 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 page B-21 in your *Summary of Benefits Handbook.*

COBRA

When You, Your Spouse or Your Other Dependents Lose Coverage

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

COBRA Qualifying Events

- Divorce or legal separation from your spouse
- Loss of eligibility by you or your dependent child
- Your death, while covered as a plan participant

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.

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 you are not sure whether or not your dependent is eligible for COBRA due to a qualifying event, please contact the HR Service Center. COBRA rights may be jeopardized if contact with the HR Service Center is not made within 60 days of the qualifying event.

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. To obtain extended coverage through Cal-COBRA, you must send a written request to accept the extended coverage to your HMO within your HMO's specified timeframe. For application materials, cost or additional information, contact your HMO at least 60 days before your federal COBRA coverage terminates.

IMPORTANT

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

Medical Plan Options

FOR MEDICARE-ELIGIBLE MEMBERS

Before you make a decision about your medical coverage, it is important to understand the differences between the Comprehensive Access Plan (CAP), the PG&E Medicare Supplemental Plan (MSP), the Retiree Optional Plan (ROP), Medicare Coordination of Benefits (COB) HMO Plans and Medicare HMOs (commonly referred to as Medicare Advantage Plans).

The following is a brief summary of how the plans work. For additional information, see the Comparison of Benefits Charts beginning on page 28. **Please note that the information on coordination of benefits with Medicare, discussed in this section, refers to medical services only, not prescription drug benefits.** Comprehensive prescription drug coverage is included in all the medical plans PG&E offers. However, there is no coordination of benefits with Medicare on prescription drugs. See the *Understanding Medicare Part D* booklet, included in your enrollment packet.

Regardless of which PG&E-sponsored plan you enroll in, prescription drug coverage is included in the plan.

Therefore, you should not enroll in the newly offered Medicare Part D coverage through a separate Prescription Drug Plan (PDP).

See the *Understanding Medicare Part D* booklet in your enrollment packet.

The Comprehensive Access Plan

This plan provides Medicare secondary coverage, plus primary prescription drug coverage. This means Medicare processes your claims first (except prescription drug claims, which are covered directly through Medco Health), and the Comprehensive Access Plan (CAP) processes your claims second. The CAP pays only the difference necessary to make your total reimbursement (Medicare's payment plus the CAP's payment) equal to the amount a non-Medicare member would receive. You may still be required to pay part of the claim.

EXAMPLE: Medicare covers laboratory services at 80 percent, while the CAP allows for total coverage of 90 percent. Therefore, the CAP will pay the 10 percent difference between 90 percent and 80 percent for lab claims. You would be responsible for paying the remaining 10 percent of the claim.

If you are Medicare-eligible, the CAP will pay this reduced amount, even if you haven't enrolled in Medicare. **To receive full benefits, be sure to enroll promptly in both Parts A and B of Medicare as soon as you become eligible.** However, as explained above and in the *Understanding Medicare Part D* booklet included in your enrollment packet, **PG&E recommends that you do *not* enroll in a Medicare Part D Prescription Drug Plan.**

The plan provides coverage worldwide, so care may be received from the physician or hospital of your choice. There is no network of providers, and you are not required to choose a primary care physician or go to a network provider to receive the highest level of benefits. For families with both Medicare and non-Medicare members, the non-Medicare members may want to use Blue Cross network providers, as described under the Retiree Optional Plan on the following page.

(continued on next page)

Retiree Optional Plan (ROP)

This plan provides Medicare secondary coverage, plus primary prescription drug coverage. Claims are processed in a fashion similar to that of the Comprehensive Access Plan (CAP). The Retiree Optional Plan has a lower monthly premium cost than the other company-sponsored medical plans administered by Blue Cross, although it has higher out-of-pocket costs when services are actually used. Like all of the other medical plans, the Retiree Optional Plan offers comprehensive coverage in the event of a major illness and protects members against catastrophic costs.

EXAMPLE: Medicare covers laboratory services at 80 percent, while the ROP only covers 70 percent. Therefore, the ROP will not make any payment after Medicare processes the claim at 80 percent. You would be responsible for paying the remaining 20 percent of the claim.

You may use any provider nationwide without having your benefits reduced. For families with both Medicare and non-Medicare members, the non-Medicare members may want to use Blue Cross network providers. By using network providers, you can take advantage of Blue Cross' discounted, contracted rates which will lower your coinsurance and protect you against being billed for costs above "reasonable and customary." Medicare members are billed at Medicare's preferred rates and, therefore, don't need to be concerned about this.

The PG&E Medicare Supplemental Plan (MSP)

This plan provides Medicare secondary coverage, plus primary prescription drug coverage. Claims are processed first by Medicare. The plan then pays 80 percent of eligible expenses that are not paid by Medicare once a $100 deductible is satisfied. The MSP is only available to retired employees on Medicare and their covered dependents who also have Medicare.

EXAMPLE: Medicare covers laboratory services at 80 percent. If your annual deductible has been met, the MSP will pay 80 percent of the remaining 20 percent, or 16 percent of the claim. You would be responsible for paying the remaining 4 percent of the claim.

There is a lifetime maximum of $10,000 for medical plan benefits for each member and a separate lifetime maximum of $10,000 for prescription drugs; however, every January the plan "restores" up to $1,000 toward each of these two lifetime maximums.

Blue Shield and Health Net Medicare Coordination of Benefits (COB) HMO Plans (formerly known as "Medicare Supplemental Plans")

This type of plan provides medical care through the HMO's network of physicians and hospitals, and you pay designated copayments for the services that you receive from the HMO. In general, the HMO will coordinate all payments with Medicare, and you will not be responsible for any additional payments beyond the designated copayments. This plan gives you the option to seek coverage through the HMO's network of physicians and hospitals or to go outside the HMO network and receive coverage from Medicare only.

Enrollment in a Medicare COB HMO plan requires members to be enrolled in Medicare Parts A and B. By enrolling in one of these plans, you will also be enrolling in the HMO's Medicare Part D prescription drug coverage (see the *Understanding Medicare Part D* booklet, included in your enrollment packet). The Medicare COB HMO plans will verify Medicare status for all new enrollees. Members who enroll but who do not have Medicare Parts A and B, or who do not agree to enroll in the HMO's Medicare Part D coverage, will be switched to the Comprehensive Access Plan (CAP) administered by Blue Cross.

Medicare HMO Plans (also known as Medicare Advantage Plans)

A Medicare HMO operates like a Medicare COB HMO plan (see description on previous page), except it only allows you to seek coverage through the Medicare HMO's network of physicians and hospitals and requires that you assign or "give away" your Medicare benefits to the HMO. By doing so, you can no longer use your Medicare benefits outside of the Medicare HMO network. However, the premiums for Medicare HMO plans typically are lower than those for Medicare COB HMO plans.

If you enroll in a Medicare HMO plan, you will automatically be enrolled in the Medicare HMO's Part D prescription drug coverage, which is included as part of the Medicare HMO's benefits. Therefore, you should not enroll in Medicare Part D through a separate Prescription Drug Plan (PDP). See the *Understanding Medicare Part D* booklet included in your enrollment packet for more information.

The Medicare HMOs offered through PG&E include Kaiser Senior Advantage (North and South), PacifiCare Secure Horizons, and Health Net Seniority Plus. Unlike the other medical plan options, if you join a Medicare HMO and then decide its not the right plan for you, you will be allowed to disenroll from the Medicare HMO and switch to the CAP plan administered by Blue Cross, provided you do so **by April 30, 2006.** In addition, you may not cancel coverage after April 30, 2006, because of changes in federal regulations.

You can switch to only the CAP Plan before April 30, 2006, and you must pay the CAP Plan's higher premium for the remainder of the year. You must also complete a Medicare HMO disenrollment form to get back the full use of your Medicare benefits (see page 26 for more information on disenrolling from a Medicare HMO).

Important Enrollment Information for Medicare-Eligible Members

For All of the Plans

It is important to enroll in Medicare Parts A and B as soon as you or your dependents are eligible. You are usually enrolled automatically in Medicare Part A, which covers hospitalization at no cost to you, when you apply for Social Security benefits. However, you need to contact the Social Security Administration to enroll in Part B coverage, which covers doctor's office visits and certain other expenses. You will pay a separate premium to the Social Security Administration for Part B coverage. If you do not obtain both Medicare Parts A and B coverage for yourself and your Medicare-eligible dependents, your PG&E medical plan will not pay those charges that would have otherwise been covered by Medicare, nor will you be eligible to enroll in a Medicare COB HMO plan or Medicare HMO plan.

For Medicare HMO Plans

- When you first enroll in a Medicare HMO, a primary care physician (PCP) will be assigned to you and any dependents you enroll (see page 10). You may select a different PCP upon receipt of your membership ID card(s) in January. The PCP(s) you select must be from the Medicare HMO's special network, which may be different than the plan's network of doctors for members not enrolled in its Medicare HMO. The PCP must be located within 30 miles of your home. If this requirement is not met, the Medicare HMO will assign a PCP that is within a 30-mile radius.
- Kaiser members do not need to designate a primary care physician.
- You must sign a Medicare HMO Enrollment form that authorizes assignment of your Medicare benefits (Parts A and B) to the HMO and you will be enrolled in Medicare Part D through the HMO. When you call the HR Service Center to enroll, the company will send you the appropriate form to complete and return. If you do not receive the form within two weeks of requesting it, you should call the HR Service Center to inquire about the status of your request.
- You must have enrolled yourself and any eligible dependents in Medicare Parts A and B. Be sure to read the enclosed *Understanding Medicare Part D* booklet, included in your enrollment packet.

(continued on next page)

If you do not meet these requirements or complete the Medicare HMO Enrollment form, you won't be able to join the Medicare HMO. Instead, you will default to the Comprehensive Access Plan (CAP) and be responsible for the premiums for that plan.

Disenrolling From a Medicare HMO. In 2006, if you want to disenroll from a Medicare HMO — for example, if you want to switch to a different plan or drop coverage altogether — you must notify the HR Service Center no later than April 30, 2006, and you must complete a "Medicare HMO Disenrollment Form" so the HMO can release your Medicare benefits back to you. This is a mandatory step in the disenrollment process and is necessary to ensure you receive maximum benefits and avoid unpaid claims.

To obtain a form, contact the HR Service Center and notify the company of your election to change medical plans. You will then be sent a disenrollment form, specific to the plan in which you are currently enrolled, to complete and return to the HR Service Center. If, for some reason, you do not receive a disenrollment form within two weeks of calling the HR Service Center, you should call again to inquire about the status of your request.

HOT Tip

Using generic, mail-order and formulary drugs can save you money. A formulary is a list of drugs that a plan will cover.

- **Open Formulary** – All brand drugs are covered at the normal copayment, or at a somewhat higher copayment if they are non-formulary drugs. The generic equivalent is often dispensed first or discounted.
- **Closed Formulary** – A drug must be on the formulary list to be covered at the normal copayment; otherwise, the member pays full cost. The generic equivalent is used when available.

Some drugs may not be covered or may require special authorization from your plan. Check with the plan's member services department directly for specifics.

How Medicare Eligibility Affects

YOUR MEDICAL PLAN OPTIONS

The company offers a variety of medical plans based on where you live. Some plans provide different benefits for their members after they turn age 65 and/or become Medicare-eligible. The plan names may even change. For example, PacifiCare's corresponding Medicare plan is called Secure Horizons.

Review your 2006 Enrollment Worksheet for the specific plans available to you. Then, review the chart below to determine the corresponding medical plan available to any dependent(s) whose eligibility for Medicare is different than your own. **Don't forget to check the monthly premium contributions for each plan, which are listed on pages 39-40.**

Non-Medicare Plans	Corresponding Plan for Medicare-Eligible Members
Blue Shield HMO	Blue Shield Medicare COB HMO Plan
Health Net HMO	Health Net Seniority Plus (Medicare HMO)* - or - Health Net Medicare COB HMO Plan
Kaiser North HMO	Kaiser Senior Advantage North (Medicare HMO)*
Kaiser South HMO	Kaiser Senior Advantage South (Medicare HMO)*
PacifiCare HMO	**PacifiCare Secure Horizons (Medicare HMO)***
NAP Plan (Blue Cross) **or** CAP Plan (Blue Cross)	CAP Plan (Blue Cross) - or - PG&E Medicare Supplemental Plan (MSP) (Blue Cross)
Retiree Optional Plan (Blue Cross)	Retiree Optional Plan (Blue Cross)

**If available in your area; based on your home ZIP Code*

EXAMPLE: You and your eligible dependent child are not eligible for Medicare, but your spouse is. You elect to enroll in the PacifiCare HMO plan. You and your child will be enrolled in PacifiCare, and your Medicare-eligible spouse will be enrolled in Secure Horizons, PacifiCare's Medicare HMO.

Please review the "Comparison of Benefits Charts for Members Under Age 65" beginning on page 29, and the "Comparison of Benefits Charts for Members on Medicare," beginning on page 34, to see the specific benefits offered by each plan.

HOT *Tip*

For most plans, you can call the plan's nurse helpline for advice if you are ill, but uncertain about whether a doctor's visit is necessary. The nurse helpline is available 24 hours, 7 days a week.

Comparison of Prescription Drug Benefits

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

The following table summarizes the prescription drug benefits for members enrolled in 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.

Provisions	Retiree Optional Plan (ROP) Members	NAP and CAP Members	PG&E Medicare Supplemental Plan (MSP) Members
Retail Drug Purchases	60% after deductible at any retail pharmacy	First three 30-day supplies at a participating pharmacy: 85% for generics, 75% for brand names. Refills beyond 90 days and coverage at non-participating pharmacies: 80% for generics, 70% for brand names. Generic Incentive Provision applies (see below).	75% after deductible. Generic Incentive Provision applies (see below).
Medco By Mail (Mail-Order) Purchases	70% after deductible for 90-day supply	90% for generic drugs and 80% for brand-name drugs. Generic Incentive Provision applies (see below).	80% after deductible. Generic Incentive Provision applies (see below).
Generic Incentive Provision	Not Applicable	Member is responsible for paying the difference between the price of a generic drug and a brand-name drug, plus coinsurance, if purchasing a brand-name drug when a generic version is available. Please note that any generic-brand price differential you pay is a non-covered expense and, thus, does not count towards your annual out-of-pocket maximum (see below). Drugs that are listed on Medco Health's "Narrow Therapeutic List" will be excluded from this mandatory generic provision.	
Deductible	$200 per person; no family maximum. Retail and mail-order deductible is combined.	No deductible	$100 per person (sperate from medical plan deductible). Retail and mail-order deductible is combined.
Out-of-Pocket Maximum	$1,500 per person up to a family maximum of $3,000. Out-of-pocket maximum coordinates the retail drug plan with the mail-order drug plan; does not coordinate with medical plan.	$500 per person up to a family maximum of $1,000. Out-of-pocket maximum coordinates the retail drug plan with the mail-order drug plan; 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.	None
Lifetime Maximum	No lifetime maximum	No lifetime maximum	$10,000 per person, with up to $1,000 restored annually (does not apply to drugs purchased before 2004); separate from medical plan lifetime maximum
Infertility, Sexual Dysfunction, Memory Enhancement and Contraceptive Drugs	50% after deductible	50% for both retail and mail-order plan, unless medically necessary. Medically necessary drugs are covered at standard reimbursement rates. Generic Incentive Provision applies (see above).	Covered only to treat serious medical conditions. Generic Incentive Provision applies (see above).

Changes for 2006 are in bold-faced type

Comparison of Benefits Chart

FOR MEMBERS UNDER AGE 65

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 this benefit chart and the EOC, the EOC will prevail.

Provisions	Health Net HMO
General	Only providers affiliated with Health Net HMO. No pre-existing condition exclusions.
Hospital Stay	No charge; includes intensive and coronary care
Skilled Nursing Facility	No charge; 100-day limit. Excludes custodial care.
Emergency Room Care	$25/visit for emergencies (waived if admitted). Must notify Health Net within 48 hours.
Outpatient Hospital Care	$10/visit
Office Visits	Office visit – $10 Home visit – $10
Urgent Care Visits	$10/visit
Routine Physical Examinations	$10/visit for basic Periodic Health Evaluation
Immunizations and Injections	Included in office visit. No charge for allergy injections if no visit with physician.
Eye Examinations	$10/visit
X-rays and Lab Tests	No charge
Pre-Admission Testing	No charge
Home Health Care	No charge
Hospice Care	No charge
Outpatient Physical Therapy	$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 drugs (through the plan): 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.
Outpatient Care	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
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.
Chiropractic/ Acupuncture Care	Not covered

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

Changes for 2006 are in bold-faced type

Comparison of Benefits Chart

FOR MEMBERS UNDER AGE 65

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 this 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.
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 and allergy testing if no office visit; $5/visit for allergy injections if no office visit.	$10/visit for immunizations and allergy testing if no office visit; $5/visit for allergy injections if no office visit.
Eye Examinations	$10/visit for screening/refraction; lenses and frames not covered.	$10/visit for screening/refraction; lenses and frames not covered.
X-rays and Lab Tests	No charge	No charge
Pre-Admission Testing	No charge	No charge
Home Health Care	No charge to members in service area when prescribed by a plan physician. Not covered for members living outside of service area.	No charge to members in service area when prescribed by a plan physician. Not covered for members living outside of service area.
Hospice Care	No charge to members in service area when prescribed by a plan physician. Not covered for members living outside of service area.	No charge to members in service area when prescribed by a plan physician. Not covered for members living outside of service area.
Outpatient Physical Therapy	$10/visit; therapy is given if in the judgment of a plan physician significant improvement is achievable.	$10/visit; therapy is given if in the judgment of a plan physician significant improvement is achievable.
Outpatient Prescription Drugs	$10 copay for up to 100-day supply when obtained at a plan pharmacy or through plan's mail-order; no annual maximum; closed formulary.	$10 copay for up to 100-day supply when obtained at a plan pharmacy or through the plan's mail-order; no annual maximum; closed formulary.
Mental Health*		
Inpatient Care	No charge for up to 30 days per calendar year; no day limit for mental health parity diagnoses.	No charge for up to 30 days per calendar year; no day limit for mental health parity diagnoses.
Outpatient Care	$10/visit (individual), $5/visit (group) for up to 20 visits per calendar year; no visit limit for mental health parity diagnoses.	$10/visit (individual), $5/visit (group) for up to 20 visits per calendar year; no visit limit for mental health parity diagnoses.
Alcohol and Drug Care		
Inpatient Care	No charge for detoxification. Also covered by separate Alcohol and Drug Care Program with referral by ValueOptions (inpatient only).	No charge for detoxification. Also covered by separate Alcohol and Drug Care Program with referral by ValueOptions (inpatient only).
Outpatient Care	$10/visit (individual); $5/visit (group).	$10/visit (individual); $5/visit (group).
Durable Medical Equipment	No charge to members in service area when prescribed by a plan physician. See plan EOC for limitations and exclusions. Not covered for members living outside of service area.	No charge to members in service area when prescribed by a plan physician. See plan EOC for limitations and exclusions. Not covered for members living outside of service area.
Chiropractic/ Acupuncture Care	Not covered	Not covered

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

Changes for 2006 are in bold-faced type

Comparison of Benefits Chart

FOR MEMBERS UNDER AGE 65

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 this benefit chart and the EOC, the EOC will prevail.

Provisions	PacifiCare HMO	Blue Shield HMO
General	Only providers affiliated with PacifiCare HMO. No pre-existing condition exclusions.	Members access the Blue Shield HMO network. No pre-existing condition exclusions.
Hospital Stay	No charge for semi-private room; includes intensive and coronary care	No charge
Skilled Nursing Facility	No charge; 100 days per calendar year from first treatment, per disability	No charge; 100-day limit
Emergency Room Care	$25/visit for emergencies (waived if admitted as an inpatient). Must notify PacifiCare within 24 hours.	$25/visit for emergencies (waived if admitted). Member needs to contact PCP within 24 hours of service.
Outpatient Hospital Care	$50/visit	$10/visit
Office Visits	Office visit – $10 Home visit – $10	Office visit – $10; $30 without referral (Access+ Specialist) – must be in the same Medical Group or IPA. Home visit – $10
Urgent Care Visits	$25/visit	$10/visit
Routine Physical Examinations	$10/visit	$10/visit according to health plan schedule
Immunizations and Injections	Included in office visit	Included in office visit. No charge for allergy injections if no visit with physician.
Eye Examinations	$10 copay for vision screening/refractions; lenses and frames not covered	$10/visit for refraction
X-rays and Lab Tests	No charge	No charge
Pre-Admission Testing	No charge	No charge
Home Health Care	No charge, up to 100 visits per calendar year	No charge
Hospice Care	No charge up to 180 days per lifetime in a facility or on an outpatient basis	No charge
Outpatient Physical Therapy	$10/visit; unlimited visits	$10/visit; as long as continued treatment is medically necessary pursuant to the treatment plan.
Outpatient Prescription Drugs	Retail drugs (up to 30-day supply): $5 copay for generic formulary, $15 copay for brand formulary, and $35 copay for non-formulary; 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	Retail drugs (up to 30-day supply): $5 copay for generic formulary, $15 copay for brand formulary, and $35 copay for non-formulary. Some drugs require preauthorization. MAIL-ORDER (through the plan): two times retail copay for up to a 90-day supply. No annual maximum; open formulary.
Mental Health*		
Inpatient Care	No charge up to 30 days per calendar year (unlimited days for parity diagnosis)	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	$20/visit up to 20 visits per calendar year with non-parity diagnoses. Severe mental illness (same as parity diagnosis): no visit limit for outpatient care at $10.	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. $5,000 annual maximum per calendar year.	No charge; preauthorization required. See plan EOC for limitations and exclusions.
Chiropractic/ Acupuncture Care	Discounts available through "PERKS" program. Contact PacifiCare for details.	Not covered

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

Comparison of Benefits Chart

FOR MEMBERS UNDER AGE 65

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	Retiree Optional Plan (ROP) 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; will experience savings if network doctor is used. $400 annual individual deductible, up to family maximum of $1,200; annual out-of-pocket maximum of $4,000 per individual (includes deductible), up to family maximum of $8,000; no lifetime maximum. 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 copay; 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; preauthorization required for non-emergency care, $250 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. 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
Office Visits	Primary care – 100% after $10 copay Specialist – 100% after $20 copay	70% after deductible
Urgent Care Visits	Primary care – 100% after $10 copay Specialist – 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.	70% after deductible
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
Hospice Care and Home Health Care	90%; requires prior authorization; $300 penalty if not obtained. Excludes custodial care.	70% 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 28 for details.	Covered by separate drug plan administered by Medco Health. See page 28 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.	 ■ 70% after deductible ■ 70% after deductible
Inpatient and Outpatient Alcohol and Drug Care	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions	70% after deductible
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.	70% after deductible, 10-visit maximum per year.
Acupuncture	80% for up to 20 visits per year from licensed acupuncturist or M.D.	70% after deductible with prior approval from Blue Cross.
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. Hearing aids – 70% up to $2800 annually

** "Eligible Expenses" are: (1) expenses for Covered Health Services that are covered by the plan; and (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 prevailing, or "Reasonable and Customary," rate charged for the same medical service in your area, 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

FOR MEMBERS UNDER AGE 65

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. 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 emergency room care, waived if admitted; 70% for outpatient surgery.
Office Visits	Primary care – 100% after $10 copay Specialist – 100% after $20 copay	70%
Urgent Care Visits	Primary care – 100% after $10 copay Specialist – 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%
Hospice Care and 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.
Outpatient Physical Therapy	80%	70%
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health. See page 28 for details.	Covered by separate drug plan administered by Medco Health. See page 28 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%; 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 prevailing, or "Reasonable and Customary," rate charged for the same medical service in your area, 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 Members Services.*

Comparison of Benefits Chart

FOR MEMBERS ON MEDICARE

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 this benefit chart and the EOC, the EOC will prevail.

Provisions	Health Net Medicare COB HMO	Health Net Seniority Plus (Medicare HMO)
General	Only providers affiliated with Health Net HMO. No pre-existing condition exclusions.	Only providers affiliated with Health Net. 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, 100-day limit	No charge, 100-day limit per benefit period. No prior hospital stay required.
Emergency Room Care	$25/visit for emergencies (waived if admitted); must notify Health Net within 48 hours.	$25/visit for emergencies (waived if admitted); must notify Health Net within 48 hours.
Outpatient Hospital Care	$10/visit	$10/visit
Office Visits	Office visit – $10 Home visit – $10	Office visit – $10 Home visit – $10
Urgent Care Visits	$10/visit	$10/visit
Routine Physical Examinations	$10/visit for basic periodic health evaluation	$10/visit
Immunizations and Injections	Included in office visit. No charge for allergy injections if no visit. with physician.	Included in office visit; exceptions: 20% copay for immunizations for foreign travel/occupational.
Eye Examinations	$10/visit	$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	Covered under Medicare
Outpatient Physical Therapy	$10/visit (provided as long as significant improvement is expected)	No charge
Outpatient Prescription Drugs	**Medicare Part D enhanced plan – see Medicare Part D insert for more information.** RETAIL (up to 30-day supply): $5 copay for generic formulary, $15 copay for brand formulary, and $35 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.	**Medicare Part D enhanced plan – see Medicare Part D insert for more information.** RETAIL (up to 30-day supply): $5 copay for generic formulary, $15 copay for brand formulary, and $35 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.
Mental Health*		
Inpatient Care	Severe mental illnesses (same as parity diagnosis): No charge; no day limit. Other mental illnesses: No charge for up to 30 days per calendar year for crisis intervention.	No charge; 190 days per lifetime.
Outpatient Care	Severe mental illnesses (same as parity diagnosis): $10/visit; no visit limit. Other mental illnesses: $20/visit, 20 visits per calendar year.	$20/visit; no maximum.
Alcohol and Drug Care		
Inpatient Care	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions	No charge. Also 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	$20/visit; no maximum. Also 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	$10/visit for Medicare-approved chiropractic services
Acupuncture	Not covered	Not covered

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

Changes for 2006 are in bold-faced type

Comparison of Benefits Chart

FOR MEMBERS ON MEDICARE

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 this benefit chart and the EOC, the EOC will prevail.

Provisions	Kaiser Senior Advantage North (Medicare HMO)	Kaiser Senior Advantage South (Medicare 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. No prior hospital stay required. 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. No prior hospital stay required. 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.
Office Visits	Office visit – $10 Home visit – No charge	Office visit – $10 Home visit – No charge
Urgent Care Visits	$10/visit at a Kaiser facility in area; $25/visit at non-Kaiser facility.	$10/visit at a Kaiser facility in area; $25/visit at non-Kaiser facility.
Routine Physical Examinations	$10/visit	$10/visit
Immunizations and Injections	$10 for immunizations and allergy testing if no office visit; $3/visit for allergy injections if no office visit.	$10 for immunizations and allergy testing if no office visit; $3/visit for allergy injections if no office visit.
Eye Examinations	$10/exam; $150 eyewear allowance including medically necessary eyewear every 24 months.	$10/exam; $150 eyewear allowance including medically necessary eyewear every 24 months.
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	Covered under Medicare for members with Medicare Parts A and B when prescribed by a plan physician. No charge to Medicare Part B-only members in service area when prescribed by a plan physician. Not covered for Medicare Part B-only members living outside of service area.	Covered under Medicare for members with Medicare Parts A and B when prescribed by a plan physician. No charge to Medicare Part B-only members in service area when prescribed by a plan physician. Not covered for Medicare Part B-only 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	**Medicare Part D enhanced plan – see Medicare Part D insert for more information.** $10 per prescription for up to 100-day supply when obtained at a plan pharmacy or through the plan's mail-order; no annual maximum; closed formulary.	**Medicare Part D enhanced plan – see Medicare Part D insert for more information.** $10 per prescription 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; 190 days lifetime. No charge for up to 45 additional days per calendar year after 190-day limit is reached; no day limit for mental health parity diagnoses.	No charge; 190 days lifetime. No charge for up to 45 additional days per calendar year after 190-day limit is reached; no day limit for mental health parity diagnoses.
Outpatient Care	$10/visit (individual); $5/visit (group); no visit limit for mental health parity diagnoses.	$10/visit (individual); $5/visit (group); 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. Not covered for members living outside of service area. See plan EOC for limitations and exclusions.	No charge to members in service area when prescribed by a plan physician. Not covered for members living outside of service area. See plan EOC for limitations and exclusions.
Chiropractic Care	Not covered	Not covered
Acupuncture	Not covered	Not covered

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

Comparison of Benefits Chart

FOR MEMBERS ON MEDICARE

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 this benefit chart and the EOC, the EOC will prevail.

Provisions	PacifiCare Secure Horizons (Medicare HMO)	Blue Shield Medicare COB HMO
General	Only providers affiliated with Secure Horizons. No pre-existing condition exclusions.	Members access the Blue Shield HMO network. No pre-existing condition exclusions.
Hospital Stay	No charge for semi-private room (private if medically necessary); includes intensive and coronary care; unlimited days.	No charge
Skilled Nursing Facility	No charge, 100 days per benefit period. No prior hospital stay required.	No charge, 100-day limit.
Emergency Room Care	$50/visit for emergencies (waived if admitted as an inpatient). Must notify Secure Horizons within 48 hours.	$25/visit for emergencies (waived if admitted). Member needs to contact PCP within 24 hours of service.
Outpatient Hospital Care	No charge	$10/visit
Office Visits	$10/visit for primary care physician or specialist	Office visit – $10; $30 without referral (Access+ Specialist) – must be in the same Medical Group or IPA. Home visit – $10
Urgent Care Visits	In-network: $10/visit Out-of-network: $25/visit	$10/visit
Routine Physical Examinations	$10/visit	$10/visit according to health plan schedule
Immunizations and Injections	Included in office visit	Included in office visit. No charge for allergy injections if no visit with physician.
Eye Examinations	$10/copay for vision screening/refractions; $75 materials allowance every 24 months. Contacts are NOT covered.	$10/visit for refraction
X-rays and Lab Tests	No charge	No charge
Pre-Admission Testing	No charge	No charge
Home Health Care	Covered in full when determined medically necessary and prescribed by a Secure Horizons-contracted provider	No charge
Hospice Care	Covered under Medicare	No charge
Outpatient Physical Therapy	No charge when authorized by a Secure Horizons affiliated provider	$10/visit; as long as continued treatment is medically necessary pursuant to the treatment plan.
Outpatient Prescription Drugs	**Medicare Part D enhanced plan – see Medicare Part D insert for more information.** RETAIL (up to 30-day supply): $10 copay for generic formulary, $20 copay for brand formulary, and $40 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.	**Medicare Part D enhanced plan – see Medicare Part D insert for more information.** RETAIL (up to 30-day supply): $5 copay for generic formulary, $15 copay for brand formulary, and $35 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.
Mental Health*		
Inpatient Care	No charge; up to 190 days per lifetime (days combined with Alcohol and Drug Care benefit).	Severe mental illnesses (same as parity diagnosis): No charge; no day limit. Other mental illnesses: No charge for up to 30 days per calendar year for crisis intervention.
Outpatient Care	$10 copay; unlimited visits.	Severe mental illnesses (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	No charge 190 days per lifetime (days combined with Mental Health benefit). Also 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	$10 copay; unlimited visits. Also 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/ Acupuncture	$10 copay, 12 visits for chiropractic care. Contact Secure Horizons for details.	Not covered

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

Changes for 2006 are in bold-faced type

Comparison of Benefits Chart

FOR MEMBERS ON MEDICARE

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	PG&E Medicare Supplemental Plan (MSP) 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.**	Available to all retirees and eligible dependents who have Medicare (if retiree elects Medicare Supplemental Plan and spouse does not have Medicare, spouse will be enrolled in appropriate Blue Cross-administered medical plan); worldwide coverage; $100 annual individual deductible; $10,000 lifetime maximum (up to $1,000 restored each year). 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 deductible; preauthorization required for non-emergency care, $300 penalty if not obtained; covers semi-private room (private if Medically Necessary); includes intensive care.	After deductible, 80% of eligible hospital expenses not covered by Medicare
Skilled Nursing Facility	90% for semi-private room after 3 days in hospital; preauthorization required, $300 penalty if not obtained. Excludes custodial care.	After deductible, 80% of member copay amount per Medicare from 21st to 100th day of confinement. Excludes custodial care.
Outpatient Hospital and Emergency Room Care	100% after $35 copay for medical emergency or outpatient surgery; waived if admitted.	After deductible, 80% of eligible expenses not covered by Medicare
Office Visits	Primary care – 100% after $10 copay Specialist – 100% after $20 copay	After deductible, 80% of eligible expenses not covered by Medicare
Urgent Care Visits	Primary care – 100% after $10 copay Specialist – 100% after $20 copay	After deductible, 80% of eligible expenses not covered by Medicare
Routine Physical Examinations	Primary care – 100% after $10 copay Specialist – 100% after $20 copay; lab/X-ray covered separately.	Not covered
Immunizations and Injections	95%	Not covered
Eye Examinations	Not covered	Not covered
X-rays and Lab Tests	90%	After deductible, 80% of eligible expenses not covered by Medicare
Pre-Admission Testing	95%	After deductible, 80% of eligible expenses not covered by Medicare
Hospice Care and Home Health Care	90%; requires prior authorization; $300 penalty if not obtained. Excludes custodial care.	After deductible, 80% of eligible expenses not covered by Medicare Excludes custodial care.
Outpatient Physical Therapy	80%	After deductible, 80% of eligible expenses not covered by Medicare
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health. See page 28 for details.	Covered by separate drug plan administered by Medco Health. See page 28 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.	■ After deductible, 80% of eligible expenses not covered by Medicare ■ Not covered
Alcohol and Drug Care	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions	Not covered
Durable Medical Equipment	80%; preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained.	After deductible, 80% of eligible expenses not covered by Medicare
Chiropractic Care	80% for Medically Necessary care only; preauthorization by ASHN required after initial visit.	After deductible, 80% of eligible expenses not covered by Medicare. Services must be Medically Necessary.
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.	

** "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 prevailing, or "Reasonable and Customary," rate charged for the same medical service in your area, 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 Members Services.*

Comparison of Benefits Chart

FOR MEMBERS ON MEDICARE

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

Provisions	Retiree Optional Plan (ROP) Administered by Blue Cross
General	May use provider of choice; will experience savings if network doctor is used. $400 annual individual deductible, up to family maximum of $1,200; annual out-of-pocket maximum of $4,000 per individual (includes deductible), up to family maximum of $8,000; no lifetime maximum. No pre-existing condition exclusions. *All plan benefits and out-of-pocket maximums are based on Eligible Expenses only.**
Hospital Stay	70% after deductible; preauthorization required for non-emergency care, $250 penalty if not obtained; covers semi-private room (private if Medically Necessary); includes intensive care.
Skilled Nursing Facility	70% for semi-private room after 3 days in hospital. Excludes custodial care.
Outpatient Hospital and Emergency Room Care	70% after deductible
Office Visits	70% after deductible
Urgent Care Visits	70% after deductible
Routine Physical Examinations	70% after deductible
Immunizations and Injections	70% after deductible
Eye Examinations	Not covered
X-rays and Lab Tests	70% after deductible
Pre-Admission Testing	70% after deductible
Hospice Care and Home Health Care	70% after deductible; requires prior authorization. Excludes custodial care.
Outpatient Physical Therapy	70% after deductible
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health. See page 28 for details.
Mental Health Inpatient Care Outpatient Care	 70% after deductible 70% after deductible
Alcohol and Drug Care	70% after deductible
Durable Medical Equipment	70% after deductible
Chiropractic Care	70% after deductible, 10-visit maximum per year.
Acupuncture	70% after deductible with prior approval from Blue Cross
Other Benefits	Infertility – 70% after deductible; $7,000 lifetime maximum. Hearing aids – 70% up to $2800 annually

** "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 prevailing, or "Reasonable and Customary," rate charged for the same medical service in your area, 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

Medical Plan Monthly Premium Contributions

2006 FOR MEMBERS OVER AGE 65 AND/OR ON MEDICARE, WITH 25 YEARS OR MORE OF CREDITED SERVICE*

Please refer to your 2006 Enrollment Worksheet to see which plans you are eligible to join.

Over-65 Medical Plan Option(s)	Retiree Only	Retiree Plus Spouse/DP Under 65	Retiree Plus Spouse/DP Over 65	Retiree Plus Child(ren)	Retiree Plus Family (Spouse/DP Under 65)	Retiree Plus Family (Spouse/DP Over 65)	Surviving Dependent Over-65	Surviving Dependent Over-65 Plus Child(ren)
CAP Plan (Medicare Supplemental Plan)	220.60	683.09	441.20	533.20	995.68	753.80	309.84	709.51
PG&E Medicare Supplemental Plan (MSP)	84.25	546.74	168.50	396.85	859.33	481.10	171.32	570.99
Retiree Optional Plan (ROP)	22.01	247.35	44.02	162.14	387.48	269.36	109.08	336.28
Blue Shield Medicare COB HMO	259.16	599.31	518.32	482.16	822.31	741.32	346.23	656.30
Health Net Seniority Plus (Medicare HMO)	105.47	458.43	210.94	338.43	691.38	443.90	192.54	512.57
Health Net Medicare COB HMO	221.61	574.57	443.22	454.57	807.52	676.17	308.68	628.71
Kaiser Senior Advantage North or South (Medicare HMO)	138.64	438.67	277.28	333.09	633.13	471.73	225.71	507.23
PacifiCare Secure Horizons (Medicare HMO)	89.35	388.66	178.70	311.03	648.47	438.52	176.42	485.17

** The company contribution will be prorated for retirees who retired after 2003 with less than 25 years of credited service. Please refer to your 2006 Enrollment Worksheet to see your actual premium contribution amount.*

These rates do not include the Medicare Part B refund for Medicare members.

DP = Registered Domestic Partner (not applicable for Surviving Dependents)

Medical Plan Monthly Premium Contributions

2006 FOR MEMBERS UNDER AGE 65 AND NOT ON MEDICARE, WITH 25 YEARS OR MORE OF CREDITED SERVICE*

Please refer to your 2006 Enrollment Worksheet to see which plans you are eligible to join.

Under-65 Medical Plan Option(s)	Retiree Only	Retiree Plus Spouse/DP Under 65	Retiree Plus Spouse/DP Over 65	Retiree Plus Child(ren)	Retiree Plus Family (Spouse/DP Under 65)	Retiree Plus Family (Spouse/DP Over 65)	Surviving Dependent Under-65	Surviving Dependent Under-65 Plus Child(ren)
NAP or **CAP Plan**	236.68	496.01	377.51	424.82	683.78	514.05	549.56	949.22
Retiree Optional Plan	21.10	43.28	0.00	36.77	58.60	0.00	312.41	539.61
Blue Shield HMO	122.97	259.96	302.36	221.51	358.14	349.30	386.33	696.40
Health Net HMO	137.12	286.92	(see below)	245.61	395.05	(see below)	440.03	760.06
■ with Medicare-eligible spouse/DP enrolled in Health Net Medicare COB HMO			278.96			335.85		
■ with Medicare-eligible spouse/DP enrolled in Health Net Seniority Plus			162.82			219.77		
Kaiser North or South	89.00	185.87	147.87	159.00	255.51	166.26	352.26	633.79
PacifiCare HMO	123.02	257.32	132.60	220.24	354.16	216.36	424.53	733.27

** The company contribution will be prorated for retirees with less than 25 years of credited service. Please refer to your 2006 Enrollment Worksheet to see your actual premium contribution amount.*

If Medicare is the primary payor for you or a dependent, your required premiums may be less than what is stated above. Refer to your 2006 Enrollment Worksheet to see your actual premium contribution amount.

These rates do not include the Medicare Part B refund for Medicare members.

DP = Registered Domestic Partner (not applicable for Surviving Dependents)

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	Health Net Seniority Plus	Kaiser North & South	Kaiser Senior Advantage North & South	PacifiCare HMO	PacifiCare Secure Horizons
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				▲	▲		

Note: Blue Shield and Health Net offer Medicare Coordination of Benefits (COB) HMO plans that are accessible in the same counties as their standard HMO plans.

Pacific Gas and Electric Company®

Where to Get Help

Topic	Contact	Phone Number
Questions About Enrollment or Benefits	PG&E HR Service Center or refer to your *Summary of Benefits Handbook*	415-972-7077 or 800-700-0057
Directories	Please call the member services number listed below	
Social Security Administration		800-772-1213

Member Services Contacts

Plan	Phone Number	Web Site
Blue Shield HMO and **Medicare COB HMO**	800-443-5005	www.mylifepath.com
Health Net HMO and **Medicare COB HMO**	800-522-0088	www.healthnet.com
Health Net Seniority Plus		www.healthnet.com
Current Members	800-275-4737	
Prospective Members	800-596-6565	
Kaiser (North and South)	800-464-4000	www.my.kaiserpermanente.org/ca/pge
Kaiser Senior Advantage (North and South)	800-443-0815	www.my.kaiserpermanente.org/ca/pge
PacifiCare HMO	800-624-8822	www.pacificare.com
PacifiCare Secure Horizons	800-228-2144	www.securehorizons.com
PG&E Medical Plans (Administered by Blue Cross of California)	800-964-0530	www.bluecrossca.com *or* www.bluecrossca.com/clients/pge
Network Access Plan (NAP)		
Comprehensive Access Plan (CAP)		
PG&E Medicare Supplemental Plan (MSP)		
Retiree Optional Plan (ROP)		
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