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Visit ***PG&E@Work For Me > Open Enrollment > Related Links***

Open Enrollment is October 25–November 7

Benefits 2014

Dear PG&E Retirees and Surviving Dependents:

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

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

John Simon
Senior Vice President, Human Resources

PG&E®

Medicare Coverage

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

Summary of Material Modifications (October 2013)

This *Benefits 2014* brochure for Retirees and Surviving Dependents is designed, in part, to make you aware of important changes that have been made to The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents (referred to as the "Health Care Plan"). Your 2014 enrollment materials are not an exhaustive explanation of the Health Care Plan. Additional information about the Health Care Plan is contained in the documents entitled *The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents*, the *Summary of Benefits Handbook* and the Summaries of Material Modifications (SMMs). These materials, the enrollment guides designated as Summaries of Material Modifications, and the Evidence of Coverage booklets or service provider agreements issued by the HMOs and by the Kaiser EPO collectively constitute the official plan document.

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

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

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

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WELCOME

What's New for 2014?

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

NEW BENEFIT: Medically Necessary Hearing Aids Covered

All plans will cover medically necessary hearing aids and related exams, fittings, adjustments and repairs starting January 1, 2014:

- **All Anthem plans, Health Net plans and the Kaiser EPO** will cover 80 percent of the allowable cost for medically necessary hearing aids and related expenses. These plans will cover one hearing aid per ear every three years, and they'll automatically process your claims.
- **All Blue Shield plans** will pay 100 percent up to a flat dollar allowance of $2,000 or 80 percent of the total cost—whichever is greater—for medically necessary hearing aids and related expenses. The $2,000 allowance from Blue Shield is available every two years; any supplement above this allowance is available every three years.
- **The Kaiser Senior Advantage Plan** will pay 100 percent up to a flat dollar allowance of $1,000 or 80 percent of the total cost—whichever is greater—for one medically necessary hearing aid per ear and related expenses every three years.

BLUE SHIELD AND KAISER SENIOR ADVANTAGE HEARING AID CLAIMS

If you're enrolled in a Blue Shield or Kaiser Senior Advantage plan, you may need to file claims for your medically necessary hearing aids and related expenses. Here's how your hearing aid benefit will work:

1. Blue Shield or Kaiser Senior Advantage will automatically pay 100 percent up to the flat dollar allowance for medically necessary hearing aids and related expenses. You need to exhaust this flat dollar allowance first.
2. If your medical plan's flat dollar allowance doesn't cover 100 percent of the cost, then you'll need to pay the difference.
3. In addition, if the flat dollar allowance doesn't cover at least 80 percent of the total cost, you can file a claim for additional reimbursement with the administrator that processes the hearing aid benefit—called Your Spending Account (YSA). You'll need to submit either your Explanation of Benefits (EOB) statement or Purchase Agreement from your medical plan along with the total bill. If Blue Shield or Kaiser Senior Advantage says your hearing aid was not medically necessary, then YSA won't pay anything.

NO QUESTIONS? NO NEED TO CALL

If you're not making any changes to your benefits or if you have no questions, there is no need to call the HR Service Center.

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

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

DO YOU HAVE A NEW ADDRESS OR PHONE NUMBER?

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

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

The minimum you can get as a total benefit is 80 percent of the cost. This includes your Blue Shield or Kaiser Senior Advantage allowance plus any reimbursement from YSA.

To request a YSA claim form for a medically necessary hearing aid purchased in 2014, call YSA at **1-800-964-9902**. Representatives are available Monday through Friday, 5 a.m. to 5 p.m. Pacific Time. You can also submit your claim online at **www.yourspendingaccount.com/pge**. Your payment amount will be displayed online once it's been approved and processed.

HSA Medical Plan Going Away

The Health Savings Account (HSA) Medical Plan for non-Medicare retirees will no longer be available. If you're currently enrolled in the HSA Medical Plan and you don't elect a different plan for 2014, you and your currently enrolled dependents will be automatically enrolled in the Anthem Network Access Plan (NAP) or Comprehensive Access Plan (CAP) for 2014, depending where you live.

The Health Savings Account (HSA) will be closed to new contributions, but you can still withdraw unused HSA balances for eligible health expenses. For 2014 and 2015, UMB Bank will continue to administer your account, and PG&E will continue to pay UMB Bank account administration fees. Starting in 2016, you'll need to pay the account administration fees to UMB Bank.

To access your HSA balance, you can use the UMB Visa card you'll receive in January with your account balance preloaded on it, or you can submit claims for reimbursement to UMB Bank. You'll get a letter with more instructions about how to access your HSA account balance in January 2014.

New Federal Tax Treatment of Benefits for Same-Sex Spouses

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

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

Health Care Reform Update

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

WHAT DOES IT MEAN FOR YOU?

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

All PG&E-sponsored medical plans meet the PPACA's requirements of minimum essential coverage. If you'll be enrolled in a PG&E-sponsored medical plan for 2014 or if you'll have other qualifying coverage like Medicare Part A, you don't need to purchase individual coverage—like the plans available through the marketplace—but you may want to consider other coverage if you're not yet eligible for Medicare. If you'll be enrolled in another employer's plan (through your spouse, for example), check with that plan to make sure it meets the federal requirements.

ARE YOU A RETIREE WHO CANCELLED YOUR PG&E COVERAGE?

If you opted out of your PG&E-sponsored medical coverage on or after January 1, 2003, and you didn't call the HR Service Center to request an Open Enrollment packet by September 1 of this year, your next opportunity to re-enroll in a PG&E-sponsored medical plan will be next fall for coverage effective January 1, 2015. You'll need to call the HR Service Center by **September 1, 2014**, to initiate re-enrollment for 2015.

If you won't have other employer-sponsored coverage, Medicare Part A coverage or other qualifying coverage for 2014, you'll need to enroll in an individual plan, whether through the marketplace or elsewhere. Visit **coveredca.com** to learn about some marketplace options in California.

IF YOU'RE NOT ELIGIBLE FOR MEDICARE

If you're not eligible for Medicare, you'll still be able to enroll in a PG&E-sponsored medical plan. However, you may be able to get a better deal on the marketplace if you qualify for a federal subsidy. To qualify for a federal subsidy:

- You can't be enrolled in any other coverage (including PG&E-sponsored coverage)—and
- Your projected 2014 income has to be between 100 and 400 percent of the federal poverty level (for 2013, this equates to $46,000 for an individual and up to $94,000 for a family of four).

Visit **coveredca.com** to see marketplace options in California.

If you decide to drop your PG&E coverage for 2014 and enroll in other health insurance—including insurance offered through the marketplace—any balance in your Retiree Medical Savings Account (RMSA) or Retiree Premium Offset Account (RPOA) available with the Retiree Medical Employer Contribution (RMEC) program will be frozen. You won't lose your RMSA or RPOA balance, but you can't use it to pay for non-PG&E-sponsored health care. You can only use it to help pay for PG&E-sponsored medical coverage. Your RMSA or RPOA balance will be unfrozen if you later re-enroll in a PG&E-sponsored medical plan. Similarly, if you're a RMEC participant, PG&E only helps pay a portion of your PG&E-sponsored medical plan premiums. PG&E will not make RMEC contributions to pay for any non-PG&E coverage you may choose to enroll in.

If you're a surviving spouse or dependent and you decide to drop your PG&E coverage for 2014, you won't be eligible to enroll in PG&E-sponsored coverage in the future.

IF YOU'RE ON MEDICARE

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

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

WATCH OUT FOR SCAMS

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

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

Wellness

PG&E's wellness benefits work hand in hand with your medical coverage to help you maintain or improve your health. After all, the important thing is to feel well enough to enjoy life's important events with your friends and family. These resources can help you do that.

Preventive Benefits	Your medical plan offers checkups that can help keep you healthy for the long term: • Annual physicals • Health screenings as recommended by your medical plan—such as colonoscopies, prostate exams, OB/GYN exams and mammograms
Tobacco Cessation	When it comes to quitting smoking or chewing, each person's challenges and needs are unique. Provant Health Solutions offers a free tobacco cessation program for you and your spouse or domestic partner. You'll get a five-week, phone-based program with one-on-one support with a certified tobacco cessation specialist. Nicotine replacement therapy is available to complement the program. To get started, call Provant at **1-866-271-8144**. Representatives are available Monday through Friday, 5 a.m. to 5 p.m. Pacific Time. You can start participating in the program anytime; you don't have to wait for 2014.
Free Flu Shots	**Anthem members:** You can get your seasonal flu shots at no cost at any of the retail pharmacies that sponsor flu shots in the Express Scripts retail pharmacy network. You'll need to have your Express Scripts Health ID card with you for claims processing. **Blue Shield, Health Net and Kaiser members:** You can get your free flu shot from your primary care physician (PCP).

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REVIEW

Medical

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

The medical plan options available to you are based on:

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

Some plans provide different benefits to their members after their members reach age 65 or become eligible for Medicare as the result of a disability. The plan names may even change. For example, Health Net's corresponding Medicare Advantage HMO plan is called Seniority Plus.

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

EXAMPLE:

You're eligible for Medicare, but your spouse and children are not. You enroll in the Health Net Seniority Plus plan. Your spouse and children will be enrolled in the Health Net HMO plan.

Medical Plan for Non-Medicare-Eligible Members*	Corresponding Plan for Medicare-Eligible Members*
Anthem Blue Cross Network Access Plan (NAP) or Comprehensive Access Plan (CAP)	Anthem Blue Cross Comprehensive Access Plan (CAP) or Medicare Supplemental Plan (MSP)
Anthem Blue Cross Retiree Optional Plan (ROP)	Anthem Blue Cross Retiree Optional Plan (ROP)
Blue Shield HMO	Blue Shield Medicare Coordination of Benefits (COB) HMO
Health Net HMO	Health Net Seniority Plus (Medicare Advantage HMO) or Health Net Medicare Coordination of Benefits (COB) HMO
Kaiser Permanente EPO North and South	Kaiser Permanente Senior Advantage North and South (Medicare Advantage HMO)

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

If You Move Out of Your Plan's Service Area

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

If any of your primary care physicians (PCPs), specialists, medical groups, Independent Practice Associations (IPAs), hospitals or other providers withdraw from your medical plan during 2014, you will not be able to change medical plans.

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

For Anthem Blue Cross NAP, CAP, ROP and MSP Members

Free Generic Prescription Drugs Through Express Scripts Mail Order

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

HMOs and Primary Care Physicians (PCPs)

When you first enroll in any type of HMO plan (including a Medicare COB HMO or Medicare Advantage HMO), a primary care physician (PCP) will be assigned to you and any enrolled dependents. You may select a different PCP by contacting your plan's Member Services department.

If you're eligible for Medicare, the PCP you select must be from the HMO's special Medicare provider network, which may be different than the plan's network of doctors for members not enrolled in Medicare. Your PCP must be located within 30 miles of your home—otherwise, the HMO will assign a PCP who is within a 30-mile radius.

ID CARDS

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

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

If you don't receive your new ID card on schedule, call your medical plan directly. If you need to see a doctor before your ID card arrives, use your confirmation statement as proof of coverage. Members in the Anthem Blue Cross-administered plans and Health Net HMO plans can print a copy of their ID cards from the plans' websites.

Non-Medicare Medical Plan Options

REMINDER:

The Kaiser EPO won't coordinate benefits with other Kaiser plans.

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

EXAMPLE:

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

The availability of some medical plans is based on your home ZIP code. Non-Medicare-eligible dependents of Medicare-eligible retirees will be enrolled in the non-Medicare plan that corresponds to the retiree's Medicare plan, as described on page 8. Prescription drug coverage is included in all of the medical plans PG&E sponsors.

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

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

Medicare Medical Plan Options

As a Medicare-eligible participant, (age 65 or older, or under age 65 and on Medicare due to disability), you have a choice of these PG&E-sponsored medical plans, depending on your home ZIP code:

- Comprehensive Access Plan (CAP)
- Medicare Supplemental Plan (MSP)
- Retiree Optional Plan (ROP)
- Medicare Coordination of Benefits (COB) HMO plans
- Medicare Advantage HMO plans

Under the CAP, MSP and ROP, Medicare processes your claims first, except for most prescription drug claims, which will be processed first by Express Scripts. For eligible medical expenses, the CAP, MSP and ROP provide secondary coverage—in other words, these plans process your medical claims after Medicare processes your claims:

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

The Medicare COB HMOs and Medicare Advantage HMOs coordinate their benefits with Medicare so you typically don't have to file claims. Special rules apply; please see the table starting on the next page for details.

IMPORTANT:

Switching from Medicare Advantage HMO Coverage

The **Kaiser Permanente Senior Advantage Plan** and the **Health Net Seniority Plus Plan** are Medicare Advantage HMOs. If you enrolled in one of these plans, you assigned your Medicare benefits to the HMO—in other words, you gave up control of your Medicare benefits, so you can't use them. Only your HMO can use them. That's how Medicare Advantage HMOs work.

If you're currently enrolled in **Kaiser Senior Advantage** or **Health Net Seniority Plus** and you want to switch to any other PG&E-sponsored plan, you'll need to follow these steps:

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

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

Medicare Plans	Overview For benefit details, see the Medical Plan Comparison Charts in your enrollment packet	Notes
Comprehensive Access Plan (CAP)*	The CAP offers coverage from any licensed physician or hospital. There is no network of providers and you don't have to choose a primary care physician. **Prescription drug coverage** under the CAP is administered by Express Scripts. There is no direct coordination of benefits with Medicare on prescription drugs except for some drugs covered by Medicare Part B. See the Medical Plan Comparison Charts for details.	**The CAP pays only the difference necessary** to make your total reimbursement (Medicare's payment + CAP's payment) equal to the amount a non-Medicare member would receive. You still may be required to pay part of the claim.
Medicare Supplemental Plan (MSP)*	The MSP is available only to Medicare-eligible retirees and dependents. There is no network of providers and you don't have to choose a primary care physician. The MSP pays 80% of eligible expenses not paid by Medicare after you pay a $100 deductible. **Prescription drug coverage** under the MSP is administered by Express Scripts. There is no direct coordination of benefits with Medicare on prescription drugs except for some drugs covered by Medicare Part B. See the Medical Plan Comparison Charts for details.	**The MSP has a $10,000 lifetime maximum medical plan benefit for each member** and a separate $10,000 lifetime maximum for prescription drugs for each member. However, every January, the plan "restores" up to $1,000 toward each of these two maximums. The lifetime limit does not include amounts paid by Medicare. If you're enrolled in the MSP and you reach the plan's lifetime maximum benefit limit for either medical or prescription drug benefits, you may choose another plan in your ZIP code/service area within 31 days after reaching the limit. Call the HR Service Center as soon as you're notified by either Anthem Blue Cross or Express Scripts that you have exhausted your $10,000 lifetime maximum benefit limit. You will have to pay any new deductibles in full for the new plan if you switch plans midyear.
Retiree Optional Plan (ROP)*	The ROP lets you use any licensed provider. In exchange for lower monthly contributions, you pay higher out-of-pocket costs when you use medical services. The ROP covers most eligible medical expenses at 70% after you meet the plan's deductibles. **Prescription drug coverage** under the ROP is administered by Express Scripts. There is no direct coordination of benefits with Medicare on prescription drugs except for some drugs covered by Medicare Part B. See the Medical Plan Comparison Charts for details.	**The ROP pays only the difference necessary** to make your total reimbursement (Medicare's payment + ROP's payment) equal to the amount a non-Medicare member would receive. You still may be required to pay part of the claim.

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

Medicare Plans	Overview For benefit details, see the Medical Plan Comparison Charts in your enrollment packet	Notes
Medicare Coordination of Benefits (COB) HMO Plans	PG&E-sponsored Medicare COB HMO plans include: • **Blue Shield Medicare COB HMO** • **Health Net Medicare COB HMO** Benefits are highest when you use your HMO's network of physicians and hospitals, but you have the option of using licensed providers outside the HMO's network. **When you use your HMO's providers**, you pay a designated copayment at the time of service. In general, the HMO will coordinate all payments with Medicare and you will not be responsible for any additional payments beyond the designated copayments. **When you receive care outside your HMO's network**, you'll receive traditional Medicare coverage at the standard level of Medicare benefits. **Medicare COB HMO prescription drug coverage:** When you enroll in a Medicare COB HMO, you'll receive that HMO's Medicare Part D prescription drug coverage, which is considered an "enhanced" Medicare prescription drug plan. This means that the Medicare COB HMO's Medicare prescription drug plan has better benefits than the standard Medicare prescription drug benefit, without deductibles or gaps in coverage. **You should not enroll in Medicare Part D through a separate Medicare prescription drug plan outside of PG&E.** If you do so, your PG&E-sponsored medical and prescription drug benefits will be terminated.	**Special enrollment rules:** You and your Medicare-eligible dependents must be enrolled in Medicare Parts A and B before you can enroll in a Medicare COB HMO plan. The Medicare COB HMO plans require new enrollees to complete an enrollment application for the plan's Medicare Part D prescription drug coverage. Contact the HR Service Center to request the Medicare Part D prescription drug enrollment application. You'll need to return the completed enrollment application to the HR Service Center. If you don't receive the enrollment application within two weeks of your request, please call the HR Service Center to inquire about the status of your request. **If you and your Medicare-eligible dependents are not enrolled in Medicare Parts A and B**, or you do not agree to enroll in the HMO's Medicare Part D prescription drug coverage, you won't be able to join the Medicare COB HMO plan. Instead, you'll be enrolled in the CAP, and you'll be responsible for the contributions for that plan.

continued on next page

IMPORTANT:

Do not enroll in any Medicare Advantage plan or Medicare Part D Prescription Drug Plan that is not sponsored by PG&E.

If you do so, your PG&E-sponsored medical and prescription drug benefits will be terminated.

Medicare Plans	Overview For benefit details, see the Medical Plan Comparison Charts in your enrollment packet	Notes
Medicare Advantage HMO Plans	PG&E-sponsored Medicare Advantage HMO plans include: • **Kaiser Permanente Senior Advantage (North and South)** • **Health Net Seniority Plus** To receive benefits, you must use your HMO's network of physicians and hospitals, except for medical emergencies. **Medicare Advantage HMO Plans require that you assign or "give away" your Medicare benefits to the HMO.** By doing so, you no longer can use your Medicare benefits outside of the Medicare Advantage HMO network. However, the coverage costs for Medicare Advantage HMO plans typically are lower than those for Medicare COB HMO plans. **Medicare Advantage HMO prescription drug coverage:** When you enroll in a Medicare Advantage HMO, you'll be enrolled automatically in the Medicare HMO's Part D prescription drug plan, which is included as part of the Medicare Advantage HMO's benefits. These drug plans are considered "enhanced" Medicare prescription drug plans, meaning they have better benefits than the standard Medicare prescription drug benefit, without deductibles or gaps in coverage. **You should not enroll in Medicare Part D through a separate Medicare prescription drug plan outside of PG&E.** If you do so, your PG&E-sponsored medical and prescription drug benefits will be terminated.	**Special enrollment rules:** You and your Medicare-eligible dependents must be enrolled in Medicare Parts A and B and you must sign a Medicare Advantage HMO Enrollment form. This form authorizes assignment of your Medicare benefits (Parts A and B) to the HMO and acknowledges your understanding that you will be enrolled in a Medicare Part D prescription drug plan through the HMO. When you enroll, the HR Service Center will send you the appropriate form to complete and return. If you don't receive the form within two weeks, please call the HR Service Center to inquire about the status of the form. **If you and your dependents are not enrolled in Medicare Parts A and B**, or you do not agree to complete the Medicare Advantage HMO Enrollment form, you won't be able to join the Medicare Advantage HMO. Instead, you'll be enrolled in the CAP, and you'll be responsible for the contributions for that plan.

Medicare Part B Reimbursement for Disabled Members under Age 65

In 2014, PG&E will continue to reimburse the standard Medicare Part B premium each month to eligible disabled retirees and up to two disabled dependents who are under age 65, enrolled in Medicare Parts A and B, and enrolled in a PG&E-sponsored medical plan.

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

IMPORTANT:

You and Your Covered Dependents Must Enroll in Medicare When Eligible

Be sure to enroll in Medicare Parts A and B as soon as you or your dependents become eligible for Medicare. In addition, if you or a dependent becomes eligible for Medicare due to disability before age 65, you must notify the HR Service Center so your records can be updated and your claims can be properly coordinated with Medicare. The HR Service Center must receive a copy of your Medicare card before PG&E can begin reimbursing you for your Part B premium.

All PG&E-sponsored Medicare plans coordinate benefits with Medicare, which means they pay only the difference between what Medicare Parts A and B would pay and what the PG&E plan would pay—even if you're not enrolled in Medicare Parts A and B. To receive full benefits, you need to be covered by Medicare Parts A and B.

Typically, you're enrolled automatically in Medicare Parts A and B if you've been receiving Social Security benefits for at least two years. Otherwise, you need to contact the Social Security Administration three months before turning age 65. You must pay a separate premium to the Social Security Administration for Part B coverage.

If you and your Medicare-eligible dependents aren't enrolled in both Medicare Parts A and B when eligible, your PG&E-sponsored medical plan will **not pay the charges** that would otherwise have been covered by Medicare, and you will not be eligible to enroll in a Medicare COB HMO plan or a Medicare Advantage HMO plan. In addition, you will not qualify for Medicare Part B reimbursement from PG&E and you will have to pay Medicare a penalty to obtain Part B coverage.

HOW TO REQUEST PART B PREMIUM REIMBURSEMENT CREDITS

Once you're enrolled in Medicare Parts A and B, you must contact the HR Service Center and provide a copy of your Medicare card showing your Medicare claim number and Medicare effective date to qualify for and initiate the monthly reimbursement. PG&E will not issue reimbursement on a retroactive basis, so it's important that you send the HR Service Center a copy of your Medicare card when you first obtain Part B coverage.

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

For details about prescription drug benefits, see the Medical Plan Comparison Charts.

IMPORTANT:

Do not enroll in any Medicare Advantage plan or Medicare Part D Prescription Drug Plan that is not sponsored by PG&E.

If you do so, your PG&E-sponsored medical and prescription drug benefits will be terminated.

Prescription Drug Coverage Provided through PG&E-Sponsored Medical Plans

Prescription drug coverage is included in all the medical plans PG&E sponsors. However, there is no direct coordination of benefits with Medicare on prescription drugs, except for some drugs covered by Medicare Part B. Every plan that PG&E offers to Medicare-eligible participants has a higher prescription drug benefit than the basic Medicare Part D prescription drug benefit.

HOW PRESCRIPTION DRUG COVERAGE WORKS IN PG&E-SPONSORED MEDICAL PLANS

You're not enrolled in a Medicare Part D prescription drug plan if you're enrolled in an Anthem plan (CAP, MSP or ROP). Instead, you have prescription drug coverage through Express Scripts:

- CAP members remain in the same prescription drug plan, via Express Scripts, as non-Medicare CAP and NAP members.
- ROP and MSP members are also enrolled via Express Scripts, but they have different levels of coverage than CAP members.

You are enrolled in a Medicare Part D prescription drug plan if you're enrolled in one of the following plans:

- Medicare COB HMO Plan—Blue Shield Medicare COB Plan or Health Net Medicare COB Plan
- Medicare Advantage HMO Plan—Health Net Seniority Plus Plan or Kaiser Permanente Senior Advantage Plan

Your Contributions for Medical Coverage

If you qualify for PG&E-sponsored retiree medical plan coverage, you and PG&E (or if applicable, a Participating Employer)* share the cost of any PG&E-sponsored coverage.

There are two retiree medical contribution programs:

- **Retiree Medical Employer Contribution (RMEC).** This program is for eligible individuals who retired before 2011.
- **Retiree Medical Savings Account (RMSA).** This program is for eligible individuals who retire in 2011 and later.

Eligible individuals retiring September 2009 through December 2010 were able to choose the RMEC or the RMSA, effective January 1, 2011. This was a one-time, irrevocable choice.

***Note:** As used in this section, the term "PG&E" means a Participating Employer with respect to such employer's employees and retirees. See page 29 for the definition of a Participating Employer.

KEY ACRONYMS

RMEC: Retiree Medical Employer Contribution

RPOA: Retiree Premium Offset Account (available with the RMEC)

RMSA: Retiree Medical Savings Account

Retiree Medical Employer Contribution (RMEC) Program

ACTUAL PG&E CONTRIBUTION BASED ON CREDITED SERVICE

Non-Medicare retirees with 10 to 25 years of service will receive a PG&E contribution ranging from 50 to 65 percent of the cost of NAP or CAP coverage, scaled proportionately based on years and months of credited service. Annual PG&E contributions cannot exceed the following annual maximum limit, also scaled proportionately based on years and months of credited service:

- $13,000 per enrolled non-Medicare retiree, plus
- $13,000 per enrolled non-Medicare spouse or registered domestic partner, plus
- $13,000 total for enrolled non-Medicare children (this limit applies for all of your enrolled children if at least one of your enrolled children is not eligible for Medicare)

If You Retired Before 2011 or You Elected the RMEC in 2010

Under the RMEC program, PG&E's maximum contributions for retiree medical coverage are limited to set dollar amounts. PG&E pays a portion of the cost of retiree medical coverage up to an annual limit. The amount PG&E contributes toward the cost of your coverage is based on your age, the age of your spouse or domestic partner, whether you're covering any children and your years of credited service. You're responsible for paying the remaining portion of the cost of coverage. PG&E will share in the cost of medical inflation until PG&E contributions reach the new maximum dollar limit under the RMEC. After that point, participants will absorb the entire cost of coverage increases because PG&E's contribution is fixed.

If you're a RMEC participant, PG&E only helps pay a portion of your PG&E-sponsored medical plan premiums. PG&E will not make RMEC contributions to pay for any private insurance coverage you may choose to enroll in.

RMEC for Non-Medicare Participants

Each year, PG&E will contribute up to an amount equivalent to 65 percent of the monthly cost of the Anthem Blue Cross-administered NAP or CAP for that year, until the amount PG&E contributes reaches the maximum annual dollar limit. The actual annual dollar limit that PG&E will contribute is based on your years and months of credited service, as described in the column to the left.

If you enroll in another PG&E-sponsored retiree medical plan instead of the NAP or CAP, PG&E will contribute the equivalent amount to the cost of your coverage, provided however, that the maximum PG&E contribution is no more than 72 percent of the monthly cost of coverage for the plan you elect. In other words, non-Medicare retirees and non-Medicare dependents must pay at least 28 percent of their monthly coverage costs.

RMEC for Medicare Participants

PG&E increases the base monthly contribution each year by the weighted average cost increase of all PG&E Medicare plans based on the prior year's cost experience. For 2014, the base monthly contribution will be $105.67. The annual increases will continue until the amount PG&E pays for Medicare retirees with 25 or more years of credited service reaches the maximum annual limit. The maximum annual limit is:

- $2,500 per enrolled Medicare retiree, plus
- $2,500 per enrolled Medicare spouse or registered domestic partner, plus
- $2,500 total for enrolled Medicare-eligible children

In addition, PG&E's base monthly contribution for a Medicare retiree with 10 to 25 years of credited service is scaled proportionately, from $33.82 to $105.67 in 2014, based on the Medicare retiree's years and months of credited service. Annual PG&E contributions cannot exceed the maximum annual limits, also scaled proportionately based on years and months of credited service.

Medicare retirees with retirement dates in 2003 or earlier who have fewer than 25 years of service will continue to receive the full base PG&E contribution, up to the annual maximum limit.

Separate RMEC Contributions for Retirees and Dependents

Under the RMEC program, PG&E provides separate contributions for retirees, spouses or registered domestic partners and eligible children.

Following the example at the right, PG&E's highest annual contribution toward the cost of PG&E-sponsored retiree coverage would be:

- For Chuck, a Medicare retiree—up to $2,500 per year, plus
- For Sue, a non-Medicare spouse—up to $13,000 per year, plus
- For Sarah and Emma, Chuck's non-Medicare children—up to $13,000 total per year

If Sarah were eligible for Medicare and Emma was not, the total annual limit for Chuck's children still would be $13,000. The higher total limit applies for all children when at least one is not eligible for Medicare. If both Sarah and Emma were eligible for Medicare, the total limit would be $2,500.

EXAMPLE:

Medicare-Eligible Chuck and His Young Family

- **Chuck is 67 and retired from PG&E with 26 years of credited service.**
- **He's eligible for Medicare, but his wife, Sue, and their children are not.**
- **Chuck's wife and children are enrolled as dependents under his PG&E-sponsored retiree medical coverage.**

USING YOUR RPOA

Each year during Open Enrollment, if you have a positive RPOA balance, you can elect to start, stop or continue using your RPOA to pay a portion of your medical plan contributions for the upcoming calendar year.

Remember, you must deplete your RPOA50 balance before using your RPOA25. Therefore, if you elect to use your RPOA account and you have a positive RPOA50 balance, you automatically will use the RPOA50 first. If you deplete your RPOA50 balance midyear and you have an RPOA25 balance, you must begin using this balance the following month even if you would prefer to "save" it.

Retiree Premium Offset Account (RPOA) Available with the RMEC

The RPOA is intended to help retirees reduce the amount they pay for PG&E-sponsored medical plan coverage.

The RPOA is not a medical plan, nor does the account have any cash value. Rather, it's a bookkeeping account containing credits that can be used to help eligible retirees offset, or reduce, their monthly PG&E-sponsored medical plan contributions. The RPOA is fully funded by PG&E, so it costs you nothing. There are two RPOAs: The RPOA50 and the RPOA25. Not all retirees who qualified for the RPOA50 qualified for the RPOA25.

You must be enrolled in a PG&E-sponsored retiree medical plan to take advantage of the RPOA. If you drop your PG&E coverage for 2014 and enroll in private health insurance, any balance in your RPOA will be frozen. You won't lose your RPOA, but you can't use it to pay for non-PG&E-sponsored health care. You can only use your RPOA balance to help pay for PG&E-sponsored medical coverage. If you later re-enroll in a PG&E-sponsored medical plan, your RPOA balance will be unfrozen.

RPOA50

Under the RMEC, all retirees who had at least 10 years of credited service were eligible for the RPOA50. The RPOA50 was a one-time allotment of $500 for each year of credited service beyond your first 10 years of credited service, up to a maximum of $7,500.

You can use the RPOA50 to offset 50 percent of your monthly medical contributions as long as you have a balance in your RPOA50 allotment.

RPOA25

If you retired on or before January 1, 2007, with 10 or more years of credited service, you may have received an additional RPOA allotment called the RPOA25. After you have depleted your initial RPOA50 allotment, you can use the RPOA25 to offset 25 percent of your cost for PG&E-sponsored medical plan coverage. You cannot use your RPOA25 until your original RPOA50 has been depleted. If you're using the RPOA50 and you deplete that balance, usage of your RPOA25 will automatically begin the month following the month in which your RPOA50 is depleted.

CHANGING YOUR RPOA ELECTION

You may change your RPOA usage election for the coming year by indicating your election during Open Enrollment. If you don't request a change during Open Enrollment, your current RPOA usage election will remain in effect for 2014. After Open Enrollment ends, you may change your RPOA election during the year only if you have an eligible change-in-status event. For details, see your copy of the *Summary of Benefits Handbook*.

If your RPOA balance is depleted during the year, you'll be responsible for paying the full amount of your medical plan contributions through the end of the year. You will not be allowed to switch to a less expensive medical plan during the year if your RPOA account is depleted. If your RPOA account balance is low, you may want to consider switching to a less expensive medical plan during Open Enrollment.

Surviving Dependent Contributions and the RPOA

Surviving dependents pay the full cost of their medical plan coverage. In addition, all surviving dependents are eligible to "inherit" your RPOA balance if all of these conditions are met:

- They became surviving dependents on or after January 1, 2004, and
- You were eligible for the retiree RPOA, and
- An RPOA balance remained at the time of your death.

The surviving dependent can use the "inherited" RPOA balance to reduce the cost of his or her medical plan coverage until the RPOA balance is depleted or until the surviving dependent is no longer eligible for PG&E-sponsored retiree medical coverage.

Calculating Your RMEC Contributions

Your monthly contribution for medical coverage is the difference between the full cost of coverage for the plan in which you're enrolled and the amount PG&E contributes through the RMEC (and the RPOA, if applicable). You and PG&E share the cost of your PG&E-sponsored retiree medical coverage.

Check your 2014 Enrollment Worksheet to see which plans you're eligible to join and the monthly contributions for each plan.

SAMPLE 2014 MONTHLY COVERAGE COSTS UNDER THE RMEC

If you have an RPOA balance, you may use the account to reduce your monthly contribution. This example is for Tom and Elaine, a retiree* and spouse who have PG&E contributions under the RMEC program and who are both:

- Eligible for Medicare
- Enrolled in the CAP

EXAMPLE: COMPREHENSIVE ACCESS PLAN (CAP)	No RPOA Account Election	Election To Use RPOA50	Election To Use RPOA25
Monthly Cost	$701.70	$701.70	$701.70
PG&E's Contribution	-$211.34	-$211.34	-$211.34
Tom and Elaine's Contribution Without RPOA	$490.36	$490.36	$490.36
RPOA50 or RPOA25 Election	N/A	$245.18	$122.59
Tom and Elaine's Net Monthly Contribution	$490.36	$245.18	$367.77

*Assumes Tom has 25 or more years of credited service

Retiree Medical Savings Account (RMSA) Program

If You Retired in 2011 or Later or You Elected the RMSA in 2010

As of January 1, 2011, the RMSA program replaced the RMEC program for eligible individuals who retired in 2011 or later, or who elected the RMSA in 2010. Under the RMSA program, PG&E creates separate accounts for you and your eligible spouse or registered domestic partner at the time you retire. Your enrolled children won't get a separate RMSA, but you can use your RMSA to help pay for their coverage under your PG&E-sponsored retiree medical plan. Only PG&E can credit your RMSA with non-taxable contributions. You may not contribute to your account, as it has no cash value.

The balance in your RMSA is available solely to help you pay for your PG&E-sponsored retiree medical coverage. The amount PG&E contributes toward your RMSA is based on your age and years of service: The more years of service you have and the older you are when you retire, the higher the value of your RMSA. You're responsible for paying the remaining portion of the cost of coverage.

New retirees will receive the RMSA as though it has always been in place. Here's how PG&E contributes to the RMSA:

Your Account—PG&E Contributes:	Your Spouse or Registered Domestic Partner's Account*—PG&E Contributes:
$5,000 a year to your account for each year you're employed by PG&E, starting when you reach age 45 (or later if hired after age 45)	**$5,000 a year to your spouse or registered domestic partner's account** for each year you're employed by PG&E, starting when you reach age 45 (or later if hired after age 45)
Additional $1,000 a year to your account for each year of credited service beyond 15 years (including credited service before age 45)—credited at retirement	Not applicable
Up to an additional lump sum of $7,500 to your account based on your years of credited service, prorated from 10 to 25 years of service—credited at retirement (equivalent to the RPOA)	Not applicable
4.5% interest to your account, compounded annually beginning at the end of the year in which you reach age 46	**4.5% interest to your spouse or registered domestic partner's account**, compounded annually beginning at the end of the year in which you reach age 46

*For your spouse or registered domestic partner to be eligible for the RMSA, you must be married or in your registered domestic partnership on your retirement date.

LUMP-SUM ALLOTMENT AND THE RMSA

Under the RMSA, all retirees with at least 10 years of credited service can receive an allotment of $500 for each year of credited service beyond their first 10 years of credited service, up to a maximum lump-sum allotment of $7,500. This lump-sum allotment will be prorated based on your years of credited service, and will be factored into the total value of your RMSA. It won't be visible as a separate line item on the monthly pension pay statements. Because the additional allotment is included in your total RMSA balance, you'll see one RMSA deduction amount when making your monthly contributions for medical coverage.

RMSA Contributions

Each year, the RMSA will pay a monthly percentage of your cost for PG&E-sponsored retiree medical coverage until your account is depleted. At that point, you will pay 100 percent of the cost. The percentage the RMSA will pay depends on what year it is.

- In 2014, the RMSA will pay 59 percent of the cost of non-Medicare retiree medical coverage and 30 percent of the cost of Medicare retiree medical coverage.
- For non-Medicare retirees, the percentage the RMSA pays will decrease until 2016, when the percentage will stay at 55 percent for 2016 and future years. Although the payment percentage initially decreases, the actual dollar amount paid by the RMSA is likely to increase as medical inflation increases.
- For Medicare retirees, the RMSA will pay 30 percent for 2014 and future years.

Year	Non-Medicare Retirees and Spouses/ Registered Domestic Partners	Medicare Retirees and Spouses/ Registered Domestic Partners
	The RMSA will pay this percentage of retiree medical coverage costs:	
2014	59%	30%
2015	57%	30%
2016	55%	30%
2017	55%	30%
2018	55%	30%

IF YOU DROP YOUR PG&E COVERAGE

If you're a PG&E retiree and you decide to drop your PG&E-sponsored coverage for 2014 and enroll in private health insurance, any balance in your RMSA will be frozen. You won't lose your RMSA balance, but you can't use it to pay for non-PG&E-sponsored health care. You can only use it to help pay for PG&E-sponsored medical coverage. Your RMSA balance will be unfrozen if you later re-enroll in a PG&E-sponsored medical plan.

If you're a surviving spouse or dependent and you decide to drop your PG&E coverage for 2014, you will not be eligible to enroll in PG&E-sponsored coverage in the future.

Surviving Dependent Contributions and the RMSA

The RMSA of your enrolled surviving spouse or registered domestic partner will continue to help pay for his or her PG&E-sponsored retiree medical coverage as well as the cost of coverage for any enrolled eligible children until:

- The account is depleted
- The enrolled surviving spouse or registered domestic partner becomes eligible for Medicare

Then, your enrolled surviving spouse or registered domestic partner must pay the full cost of coverage.

In addition, your surviving dependents (spouse, registered domestic partner, children) can't use the RMSA to pay for non-PG&E-sponsored health coverage—for example, if they drop PG&E-sponsored coverage or are no longer eligible for PG&E-sponsored coverage.

Calculating Your RMSA Contributions

Your monthly contribution for medical coverage is the difference between the full cost of coverage for the plan in which you're enrolled and the amount PG&E contributes through the RMSA. You and PG&E share the cost of your PG&E-sponsored retiree medical coverage.

Check your 2014 Enrollment Worksheet to see which plans you're eligible to join and the monthly contributions for each plan.

4

ENROLL

What You Need to Do Now

As a retiree or surviving dependent, you have two options to enroll:

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

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

Enrolling Online During Open Enrollment

To enroll online, you'll need to use Internet Explorer (versions 5.0–8.0):

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

ENROLLING OR MAKING CHANGES TO YOUR BENEFITS

Annual Open Enrollment is your opportunity to make changes to your benefit coverage. You also get to enroll or make changes when you experience an eligible change-in-status event such as marriage or divorce. You have 31 days to make any allowable midyear changes to your benefits (180 days for the birth or adoption of a child—60 days if you're enrolled in Kaiser Senior Advantage). You must be currently enrolled in a PG&E-sponsored medical plan to request a benefit change due to a change-in-status event. For details about allowable changes, see your copy of the *Summary of Benefits Handbook*.

QUESTIONS?

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

- Email hrbenefitsquestions@exchange.pge.com (please allow three full business days for a response)
- Call **415-972-7077** or **1-800-700-0057**

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

The HR Service Center will be handling a high volume of calls during Open Enrollment. **If possible, please send your questions via email.**

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

Then, follow these steps:

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

IF YOU DON'T ENROLL DURING OPEN ENROLLMENT

If you're currently enrolled and you make no changes to your medical plan or covered dependents, you'll continue to receive your current medical coverage for yourself and your eligible, covered dependents, as listed on the enclosed 2014 Enrollment Worksheet.

If your current medical plan will no longer be available for 2014, your Enrollment Worksheet will show with an asterisk (*) the alternate medical plan you'll receive for 2014 if you don't enroll.

You'll be responsible for making any required contributions for you and your dependents' 2014 medical coverage as listed on your 2014 Enrollment Worksheet.

If you're currently *not* enrolled in a PG&E-sponsored retiree medical plan and you don't enroll, you will have no coverage for 2014.

Technical Problems?

For help with technical questions about enrolling online, please contact PG&E's Technology Service Center (TSC) by calling **415-973-9000** or **1-800-223-9007**. Representatives are available 24 hours a day, seven days a week.

5

REMEMBER

Details About Your Coverage

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

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

Please note that federal law (Medicare Secondary Payer Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (42.U.S.C.1395y(b)(7)&(b)(8)) requires the company to have Social Security numbers (SSNs) on file for many individuals enrolled in a PG&E-sponsored medical plan. This includes, among others, certain retirees and dependents covered under the Pacific Gas and Electric Health Care Plan for Retirees Surviving Dependents, regardless of age. By enrolling your eligible dependents in PG&E-sponsored health care plans, you agree to provide their SSNs. If you fail to do so, your enrolled dependent(s) will be terminated from medical coverage. If your dependent's correct SSN is missing, please contact the HR Service Center at **415-972-7077** or **1-800-700-0057**, and provide the SSN in order to continue medical coverage for that dependent.

YOU CAN ENROLL CHILDREN UP TO AGE 26

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

Are you a retiree who cancelled your PG&E coverage?

If you opted out of your PG&E-sponsored medical coverage on or after January 1, 2003, and you didn't call the HR Service Center to request an Open Enrollment packet by September 1 of this year, your next opportunity to re-enroll in a PG&E-sponsored medical plan will be next fall for coverage effective January 1, 2015. You'll need to call the HR Service Center by September 1, 2014, to initiate re-enrollment for 2015.

If you don't enroll for coverage in 2014 and you don't notify the HR Service Center by September 1, 2014, that you want coverage for 2015, you won't be able to re-enroll for 2015—even if you cancelled PG&E-sponsored coverage because you had other medical coverage and you subsequently lost that other coverage.

The only exception is for a retiree enrolled as a dependent of an active PG&E employee in a PG&E-sponsored medical plan. If you lose your dependent coverage midyear, you can enroll in retiree coverage midyear and you won't need to wait until the next Open Enrollment period to enroll.

Note: The following people can't ever re-enroll for PG&E-sponsored retiree medical coverage:

- Retirees who dropped PG&E-sponsored retiree medical coverage before January 1, 2003
- Surviving spouses or dependents who dropped PG&E-sponsored retiree medical coverage at any time

Are you a surviving dependent of an employee or retiree?

If you're a surviving dependent of an employee or retiree (if you're a spouse, registered domestic partner or eligible child), you're eligible for continued medical plan coverage if you were enrolled in a PG&E-sponsored medical plan at the time of the employee or retiree's death and you're not covered under another group plan, other than Medicare. If you're a surviving child, you must meet additional eligible requirements (contact the HR Service Center for more information).

If you marry or enter into a domestic partnership, you'll no longer be eligible for PG&E-sponsored coverage—even if your new spouse or domestic partner has no other coverage. To avoid penalties, notify the HR Service Center as soon as you marry or enter into a domestic partnership.

Is your dependent child disabled?

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

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

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

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

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

Did you skip a premium payment or enroll an ineligible dependent?

If you're a retiree and you don't pay your medical plan contributions or any required restitution for covering ineligible dependents, your coverage will be permanently cancelled and you won't be able to re-enroll in a PG&E-sponsored medical plan again.

It's your responsibility to make sure all dependents you enroll for coverage are eligible. You must drop dependents from coverage within 31 days of the date on which they become ineligible for coverage. All participants who cover ineligible dependents will be required to make restitution to the Participating Employer* for health care coverage, up to two full years' of the cost of coverage. To drop ineligible dependents, call the HR Service Center at the phone number shown on the back cover.

*The Participating Employers offering health coverage for 2014 are Pacific Gas and Electric Company (PG&E); PG&E Corporation; PG&E Corporation Support Services, Inc.; and PG&E Corporation Support Services II, Inc.

Member Services Information

PLAN AND CONTACT INFORMATION		
MEDICAL	**CONTACT**	**GROUP NUMBER**
Blue Shield HMO and Medicare Coordination of Benefits (COB) HMO Representatives are available: • Monday–Thursday, 7 a.m.–7 p.m. Pacific Time • Friday, 9 a.m.–7 p.m. Pacific Time	**1-888-235-1765** **www.blueshieldca.com/pge**	H11473
Health Net HMO Representatives are available Monday–Friday, 8 a.m.–6 p.m. Pacific Time	**1-800-522-0088** **www.healthnet.com**	68992N
Health Net Medicare Coordination of Benefits (COB) HMO **Medical questions:** Health Net representatives are available Monday–Friday, 8 a.m.–6 p.m. Pacific Time **Pharmacy questions:** SilverScript representatives are available 24/7; closed Thanksgiving and Christmas	Medical questions: **1-800-522-0088** Pharmacy questions: **1-888-648-9626** **www.healthnet.com**	68992M
Health Net Seniority Plus Representatives are available Monday–Friday, 7:30 a.m.–5 p.m. Pacific Time	Current members: **1-800-275-4737** Prospective members: **1-800-596-6565** **www.healthnet.com**	68992S
Kaiser Permanente EPO (North and South) Representatives are available: • Monday–Friday, 7 a.m.–7 p.m. Pacific Time • Saturday and Sunday, 7 a.m.–3 p.m. Pacific Time	NORTH: **1-800-663-1771** SOUTH: **1-800-533-1833** **www.my.kp.org/ca/pge**	**NORTH** Corporation: 738-003 Utility: 603702 **SOUTH** Corporation: 107932-5 Utility: 231142
Kaiser Permanente Senior Advantage (North and South) Representatives are available Monday–Friday, 8 a.m.–5 p.m. Pacific Time	**1-800-443-0815** **www.my.kp.org/ca/pge**	**NORTH:** 738 **SOUTH:** 107932
Hearing Aid Reimbursement for Blue Shield and Kaiser Senior Advantage Plans Representatives are available Monday–Friday, 5 a.m.–5 p.m. Pacific Time	Contact Your Spending Account (YSA) **1-800-964-9902**	N/A
Anthem Blue Cross-Administered Plans: **Network Access Plan (NAP)** **Comprehensive Access Plan (CAP)** **Retiree Optional Plan (ROP)** **Medicare Supplemental Plan (MSP)** Representatives are available Monday–Friday, 7 a.m.–8 p.m. Pacific Time	**1-800-964-0530** **www.anthem.com/ca/pge**	PZG170157

PLAN AND CONTACT INFORMATION		
PRESCRIPTION DRUG	**CONTACT**	**GROUP NUMBER**
Prescription Drug Plan Administered by Express Scripts For NAP, CAP, ROP and MSP Representatives are available 24/7; closed Thanksgiving and Christmas	**1-800-718-6590** **www.express-scripts.com**	PGE0000
Prescription drug benefits for the HMOs are included in the HMO plans.	N/A	N/A
MENTAL HEALTH AND SUBSTANCE ABUSE	**CONTACT**	**GROUP NUMBER**
Mental Health and Substance Abuse (MHSA) Program Administered by ValueOptions For NAP, CAP, all HMOs (including Medicare COB HMOs and Medicare Advantage HMOs), Kaiser EPO Representatives are available 24/7	**1-800-562-3588** **www.valueoptions.com**	N/A
OTHER BENEFITS	**CONTACT**	**GROUP NUMBER**
COBRA Administered by Ceridian Representatives are available Monday–Friday, 5 a.m.–5 p.m. Pacific Time	**1-800-877-7994** **www.ceridian-benefits.com**	N/A
Health Savings Account Administered by UMB Bank Representatives are available: • Monday–Friday, 5 a.m.–5:30 p.m. Pacific Time • Saturday, 6 a.m.–3 p.m. Pacific Time	**1-866-520-4HSA (4472)**	N/A
Tobacco Cessation Program Administered by Provant Health Solutions Representatives are available Monday–Friday, 5 a.m.–5 p.m. Pacific Time	**1-866-271-8144**	N/A
Allsup, Inc. Social Security Advocacy: Help enrolling in Medicare for potentially eligible disabled retirees and dependents Representatives are available Monday–Friday, 6 a.m.–3 p.m. Pacific Time	**1-888-339-0743**	N/A

PG&E Benefits Information and References

PG&E HR Service Center For benefit and enrollment questions Representatives are available Monday–Friday, 7:30 a.m.–5 p.m. Pacific Time	hrbenefitsquestions@exchange.pge.com **415-972-7077** or **1-800-700-0057**
PG&E Technology Service Center (TSC) For help logging in to *PG&E@WorkForMe* Representatives are available 24 hours a day, 7 days a week	**415-973-9000** or **1-800-223-9007**
***PG&E@Work For Me* on the Internet**	https://myportal.pge.com
PG&E's *Summary of Benefits Handbook*	Go to *PG&E@Work For Me* **> Open Enrollment > Related Links**. Contact the HR Service Center to request a copy free of charge.
IRS Publications	www.irs.gov **1-800-829-3676**
Social Security Administration	**1-800-772-1213**
Medicare	www.medicare.gov **1-800-MEDICARE (1-800-633-4227)**