2010 Live Bright

Supplement to Your Enrollment Guide

Summary of Material Modifications (October 2009)

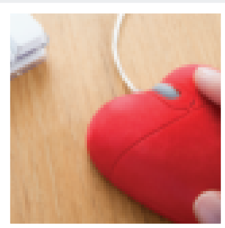
The 2010 Benefits Enrollment Guide and Supplement constitute a Summary of Material Modifications to the PG&E Health Care Plans.

The Benefits Enrollment Guide for Management and Administrative & Technical Employees*, the* Benefits Enrollment Guide for Employees Represented by the IBEW, ESC and SEIU*, the* Benefits Enrollment Guide for Employees on Long-Term Disability*, the B*enefits Enrollment Guide for Retirees and Surviving Dependents *and the* Supplement to Your 2010 Benefits Enrollment Guide *(referred to collectively as the "Enrollment Guides") are designed, in part, to: (1) make you aware of important changes that have been made to The Pacific Gas and Electric Company Health Care Plan for Active Employees and The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents (the "Health Care Plans"); (2) provide you with answers to some common questions that arise in connection with enrollment in the Health Care Plans; and (3) provide you with some important information about your rights under the Health Care Plans. The Enrollment Guides are not an exhaustive explanation of the Health Care Plans. Additional information about the Health Care Plans is contained in the documents entitled* The Pacific Gas and Electric Company Health Care Plan for Active Employees, 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*, including Enrollment Guides designated as Summaries of Material Modifications, as well as the* Evidence of Coverage *booklets issued by the health maintenance organizations (HMOs) and the Anthem Blue Cross SmartValue Plan. Together, these documents collectively constitute the official plan document.*

The Employee Benefits Committee of PG&E Corporation is the Plan Administrator of the Health Care Plans 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 documents, and to establish rules that are necessary for the administration of the Health Care Plans.

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

What's Inside



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Medicare Coverage

If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, please see page 11 for information about your prescription drug coverage and Medicare.

Introduction

This supplement to your *2010 Benefits Enrollment Guide* includes detailed information about eligibility, change-in-status events and COBRA, as well as other legally required information for the following benefit programs:

- The Pacific Gas and Electric Company Health Care Plan for Active Employees
- The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents
- The Pacific Gas and Electric Company Health Care Reimbursement Account Plan
- The Pacific Gas and Electric Company Dependent Care Reimbursement Account Plan
- The Pacific Gas and Electric Company Flex Plan for Management and A&T Employees
- The Pacific Gas and Electric Company Pre-Tax Plan for Union-Represented Employees

Certain plans are referred to herein collectively as "PG&E's Health Care Plans." These are the plans that provide medical, mental health, prescription drug, dental and vision coverage, as well as the flexible spending account plans.

Participating Employers

The Employers participating in the 2010 health plan Open Enrollment 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.

Eligibility

Eligibility for Employees

You and your eligible dependents may enroll in PG&E's benefit plans if you are a full-time or part-time employee of a Participating Employer. Your eligibility for specific benefit plans is determined by these factors:

- Whether you are a non-union-represented or union-represented employee
- Whether you work for PG&E Corporation, Pacific Gas and Electric Company or another Participating Employer
- Your home ZIP code

Eligibility for Retirees

For information regarding eligibility for PG&E-sponsored retiree medical benefits, please refer to the *January 2008 Summary of Benefits Handbook for Retirees and Surviving Dependents*.

Re-Enrolling after Waiving Medical Coverage

Retirees who waive medical plan coverage on or after January 1, 2003, may 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 before 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 — even if you waived PG&E-sponsored coverage because you had other medical coverage and you subsequently lost that other coverage.

Note: Retirees who dropped PG&E-sponsored retiree medical plan coverage before January 1, 2003, are not eligible to re-enroll for PG&E-sponsored medical plan coverage at any time.

Non-Payment of Retiree Medical Premiums

If you are a retiree and do not pay your medical plan premiums or any required restitution for covering ineligible dependents, your coverage will be cancelled and you will not be able to re-enroll in a PG&E-sponsored medical plan again.

Eligibility for Surviving Dependents

As a surviving dependent (spouse, registered domestic partner or eligible dependent child) of an employee or retiree, you are eligible for continued medical plan coverage if you were enrolled in a PG&E-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 meet additional eligibility criteria (contact the HR Service Center for more information).

IF YOU MARRY OR ESTABLISH A DOMESTIC PARTNERSHIP

Surviving dependents who marry or enter into a registered domestic partnership are not eligible to be covered under a PG&E-sponsored medical plan, even if the new spouse or registered domestic partner has no other medical coverage. If you marry or enter into a registered domestic partnership, please notify the HR Service Center immediately to avoid penalties.

CANCELLATION

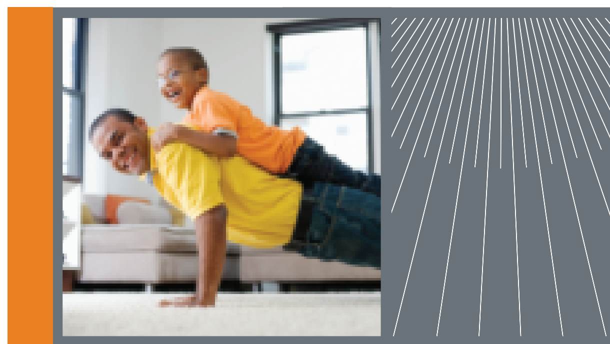
Surviving dependents who waive medical plan coverage will not be able to enroll in a PG&E-sponsored medical plan at any time in the future.

PREMIUMS

Surviving dependents pay the full cost of their required medical plan premiums; the Participating Employer makes no contribution toward the cost.

NON-PAYMENT OF SURVIVING DEPENDENT MEDICAL PREMIUMS

If you are a surviving dependent and do not pay your medical plan premiums or any required restitution for covering ineligible dependents, your coverage will be cancelled and you will not be able to re-enroll in a PG&E-sponsored medical plan again.



Eligible Dependents

Eligible dependents include:

- Your legally married spouse, legally state-recognized common-law spouse, or registered domestic partner
- Your unmarried, dependent children who are under age 19, including step-children, children born during a registered domestic partnership, 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 employees and retirees only); a child for whom your registered domestic partner is the legal guardian is not an eligible dependent
- Your unmarried, dependent children or those of your spouse/registered domestic partner who are age 19 through 23 and meet the Internal Revenue Service (IRS) definition of an eligible dependent, whether or not you claim them as dependents on your income tax returns
- Your unmarried, 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.) before they would otherwise cease to qualify as dependents, and who have been approved by a PG&E-sponsored medical plan provider for continued coverage. For more information, please contact the Member Services department of the medical plan in which you are enrolled.

- Your family member or registered domestic partner if you are both non-union-represented employees, are both union-represented employees or are both retirees. You each have the option of electing coverage as an "employee" or "retiree," or you can be covered as a "dependent" of the other. However, you may not be covered as both. In addition, you may not be covered as both an employee and a retiree.

Not Sure if Your Dependents Are Eligible?

Contact the HR Service Center:

- E-mail *HRBenefitsQuestions@exchange.pge.com*
- **Employees** call 415-973-4357 or 800-788-2363
- **Retirees** and **surviving dependents** call 415-972-7077 or 800-700-0057

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

Dependent Certification

If you have an enrolled child age 19 through 23, please be aware that you will be asked by your medical plan provider to re-certify your child's status as an IRS-eligible dependent each year you enroll your child in the plan. Be sure to respond in a timely manner, or your dependent's coverage will be dropped. If your dependent becomes ineligible, you must notify the HR Service Center at the phone number shown on the inside back cover within 31 days of the date on which your dependent becomes ineligible.

Domestic Partner Registration

If you want to add a domestic partner or the children of a domestic partner to your coverage, your partnership must be registered with a governmental agency that maintains a domestic partner registry.

Tax Implications of Coverage for Your Same-Sex Spouse, Registered Domestic Partner, and Children of Your Same-Sex Spouse or Registered Domestic Partner

FEDERAL TAXES

It is important to note that the value of the health care coverage provided for a registered domestic partner, same-sex spouse, or any enrolled dependent children of a registered domestic partner or same-sex spouse is treated as income to you for federal tax purposes. PG&E will report the value of the coverage as income on your *Form W-2* and will withhold federal income and employment taxes. The amounts taxable to you can be substantial.

An exception to these income reporting and withholding rules applies if your same-sex spouse, registered domestic partner, or children of your same-sex spouse or registered domestic partner are your tax dependents under Internal Revenue Code section 152, as amended by Code section 105(b).

Note: Many registered domestic partners and same-sex spouses do not qualify as tax dependents. However, if your enrolled, registered domestic partner, same-sex spouse, or his or her enrolled children are your tax dependents and you complete a *Certification of Tax Dependency* form, the value of the health care benefits will not be reported as taxable income. You must complete a new certification each year. If you don't receive a *Certification of Tax Dependency* form for the upcoming tax year, please call the HR Service Center to request a form. Forms received after December 31, 2009, will not be processed for 2010.

CALIFORNIA TAXES

For California income tax purposes, the value of the health care benefits provided for your same-sex spouse and your same-sex spouse's dependents are excluded from your taxable income.

For California income tax purposes, the value of the health care benefits provided to your domestic partner and your domestic partner's dependents may be excluded from your taxable income if your partnership is registered with California's Secretary of State and if certain other conditions are met. Please

contact your tax advisor and the HR Service Center for more information.

More Information about Registered Domestic Partners/Same-Sex Spouses

For more information about domestic partner registration and benefits for registered domestic partners and same-sex spouses, employees can view *Your Guide to Domestic Partner Benefits at Pacific Gas and Electric Company* on PG&E's HR intranet site. Go to **Plans, Policies & Forms > Life Changes > When You Form a New Domestic Partnership**. Or, call the HR Service Center for a copy of the guide.

National Medical Support Notices

If a Participating Employer receives a court-ordered judgment or decree requiring you to cover an eligible dependent child, the child will be enrolled in your health care plans, pursuant to the court order or judgment. Coverage for the child will be effective the first of the month following enrollment by PG&E, and your health plan premium costs will be adjusted to reflect the coverage of the child, if applicable. If you are enrolled in a health maintenance organization (HMO) and your child does not live within your HMO's service area, you will be switched to the Network Access Plan (NAP) or the Comprehensive Access Plan (CAP), as applicable for your family's ZIP code, and you will be responsible for paying the required contributions associated with the NAP and CAP plans.

Domestic Partner Dependents

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

Ineligible Dependents

Ineligible dependents include, but are not limited to:

- A divorced, legally separated, or non-legally state recognized common-law spouse, even if a court orders you to provide health care coverage
- A domestic partner if your domestic partnership has not been formally registered with a valid registry, or a former domestic partner
- Parents, step-parents, parents-in-law, grandparents and step-grandparents
- Former step-children or the step-children of a former registered domestic partner, unless they were born or adopted during the course of the registered domestic partnership or you have been appointed permanent legal guardian for them by a court
- Children age 19 through 23 who do not meet the current IRS definition of an eligible dependent
- Children age 24 and older, unless they have been approved for continued coverage under the Disabled Dependent provision
- Your disabled dependent children 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 a PG&E-sponsored medical plan provider 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 employee or retiree of a Participating Employer
- Grandchildren, nieces, nephews or other family members, unless you have legally adopted them or have been appointed permanent legal guardian for them by a court
- A family member who is a union-represented employee if you are a non-union-represented employee of a Participating Employer, or a family member who is a non-union represented employee if you are a union-represented employee of a Participating Employer.

IMPORTANT: *If both you and your spouse or registered domestic partner are an employee or retiree of a Participating Employer, only one of you may enroll each child as an eligible family member under any one benefit plan.*

Penalties for Covering Ineligible Dependents

Remember, it is your responsibility to be sure all the 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 insured (or HMO) premiums or self-insured premium equivalents.

If you are a retiree or surviving dependent and do not pay your required restitution for covering an ineligible dependent, your coverage will be cancelled and you will not be able to re-enroll in a PG&E-sponsored medical plan again.

To drop ineligible dependents, call the HR Service Center at the phone number shown on the inside back cover.

Change-in-Status Events

What's a Change-in-Status Event?

Once you've enrolled for benefits, you will not be able to make changes to your coverage until the next Open Enrollment period unless you experience an eligible change-in-status event or you retire.

Only certain change-in-status events are recognized and only limited changes in your benefit elections are permitted, due to restrictions imposed by federal legislation governing the administration of before-tax benefit plans like those sponsored by PG&E. For example, for active employees, your before-tax contributions, such as amounts contributed to your Health Care Reimbursement Account (HCRA), cannot be altered when due to a change in status relating to a domestic partnership or same-sex spouse. Eligible change-in-status events are listed below.

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

- You have a change-in-status event that will allow a change, or
- You retire

Any change you request must be consistent with your change-in-status event. For example, if you move out of your HMO's service area, you may change your medical plan, but you cannot add new dependents.

See "HIPAA Special Enrollment Rights for Employees" on page 8 for certain other permissible mid-year coverage changes.

Note: If you are enrolled in a plan that requires you to use network providers, the withdrawal of a provider, such as a doctor, medical group or hospital, from your plan's network — or the fact that you want to use a particular provider who is not part of the network — is not an eligible change-in-status event. If any of your providers withdraw from or do not contract with your medical plan's network, you must obtain services from a different provider within your plan's network for the rest of the year. You cannot change medical plans during the year if your desired provider does not contract with your plan.

Eligible Change-in-Status Events

Change-in-status events include:

- Marriage or the establishment of a registered domestic partnership (for employees and retirees only)
- Dissolution of marriage (including final divorce or annulment), legal separation or termination of a registered domestic partnership. Please note that you cannot enroll your ex-spouse or former registered domestic partner in your PG&E-sponsored health care plan, even if a court orders you to provide coverage

- The birth or adoption of a child, or your court-ordered appointment of legal guardianship for a child
- The death of your spouse, registered domestic partner or dependent child
- Your dependent child reaching the plan's age limit, getting married or entering the military
- Your dependent child regaining eligibility
- You or your dependent becoming Medicare- or Medicaid-eligible
- A change of caregivers, or a change in the cost for the services of a caregiver who is not a relative (for Dependent Care Reimbursement Account (DCRA) purposes only)
- A move out of your HMO's service area (applies to change of medical plan only)
- A change in the employment of your spouse, registered domestic partner or dependent that results in a gain or loss of health care coverage
- A change to or from full-time or part-time employment by you, your spouse, registered domestic partner or dependents, if health plan eligibility is affected. (this change-in-status event is also allowed for retirees, but only if they are already enrolled in a PG&E-sponsored health plan)
- An unpaid leave of absence taken by you, your spouse or registered domestic partner that significantly affects the cost of your health care coverage (this change-in-status event is also allowed for retirees who are already enrolled in a PG&E-sponsored health plan and whose spouse or registered domestic partner takes an unpaid leave of absence)

More information about change-in-status events is available on the HR intranet and in the *Summary of Benefits Handbook*.

Move Out of HMO Service Area

If you or your dependent move out of your HMO's service area — for example, if your enrolled child begins attending college outside of your HMO's service area — you may change the medical plan that you and your dependents are enrolled in.

IMPORTANT: *If you are a retiree who waived medical plan coverage on or after January 1, 2003, you may re-enroll in a PG&E-sponsored medical plan only during subsequent Open Enrollment periods. You may not enroll at any other time even if you have a midyear change-in-status event.* *See "Re-Enrolling after Waiving Medical Coverage" on page 2.*

Because of federal law limitations, coverage changes due to change-in-status events relating to domestic partners or same-sex spouses are only permitted if they affect or relate to after-tax benefits, not before-tax benefits

Call the HR Service Center within 31 days of a change-in-status event (60 days for births and adoptions) that may affect your benefits.

If you do not notify the HR Service Center within 31 days of the event (60 days for births and adoptions), you will not be able to make any changes until the next Open Enrollment.

Benefit changes resulting from a change-in-status event will be effective the first of the month following the date you notify the HR Service Center, except when you are adding newborns and newly adopted children. Benefit changes related to births and adoptions will be effective on the date of the birth or the date you assume physical custody or financial responsibility for the adopted child.

You must call the HR Service Center within 31 days to select a new medical plan. If you don't, the medical services you or your dependent(s) receive may not be covered. See the *Summary of Benefits Handbook* for more details.

Important Information about Adding Newborn and Newly-Adopted Children

To ensure your newborn or newly-adopted child has continuous health coverage from birth or adoption, you must call the HR Service Center **within 60 days** of your child's birth or adoption to enroll the child

in your health plan. If you don't call within 60 days, any health care expenses incurred by your child will not be covered and your child's coverage will be cancelled:

- On the 61st day for the Anthem Blue Cross medical plans; or
- Retroactive to the date of birth or adoption for the HMO plans

Your next opportunity to enroll your child for PG&E-sponsored health plan coverage will be the next Open Enrollment period. Benefit changes made during Open Enrollment are effective January 1 of the following year.

HIPAA Special Enrollment Rights for Employees

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you decline PG&E-sponsored medical, dental or vision coverage for yourself or your dependents because you have other health insurance coverage, you may be able to enroll yourself and your dependents in a PG&E-sponsored health care plan if you are an employee and:

- You or your dependents lose eligibility for the other coverage
- The other employer stops contributing toward the other coverage
- You or your dependents meet or exceed the lifetime limit on benefits payable under the other plan
- You or your dependents lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage
- You or your dependents become eligible for a state's premium assistance program under Medicaid or CHIP

In addition, if you are an employee, you may be able to enroll yourself and your dependents in a PG&E-sponsored health care plan when:

- You have a newly eligible dependent due to marriage, establishment of a registered domestic partnership, birth, adoption or placement for adoption of a child

You must request enrollment by contacting the HR Service Center:

- **Within 31 days** after the other coverage ends or the employer stops contributing to the other coverage
- **Within 31 days** of your marriage or domestic partnership registration
- **Within 60 days** of the birth, adoption or placement for adoption of a child
- **Within 60 days** of the Medicaid/CHIP eligibility change

For more information or to request special enrollment, contact the HR Service Center.

COBRA

When You or Your Dependents Lose Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows you and your enrolled dependents to continue PG&E-sponsored health care coverage if you lose coverage due to a COBRA-qualifying event. You can continue coverage under COBRA for up to 18 or 36 months, depending on the event. You pay the full cost of COBRA coverage.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning September 1, 2008, and ending December 31, 2009. If you qualify for the premium reduction, you will pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than

nine months, you will have to pay the full premium amount to continue your COBRA continuation coverage.

COBRA-Qualifying Events

You or your dependents qualify for COBRA coverage if you or your dependents lose PG&E-sponsored health care coverage due to:

- Termination of your employment (for any reason other than gross misconduct)
- A reduction in work hours
- A change in your employment status from full-time to part-time
- Your death while enrolled as a plan participant
- Divorce or legal separation from your opposite-sex spouse
- Loss of eligibility by your dependent child

PG&E and the other Participating Employers extend the same type of coverage rights to same-sex spouses, registered domestic partners, and their children that they would extend to qualified beneficiaries under COBRA. Qualifying events to obtain this COBRA-like coverage are the same for registered domestic partners and same-sex spouses as for opposite-sex spouses. For example, the dissolution of a registered domestic partnership or of a same-sex marriage is a qualifying event for obtaining COBRA-like coverage.

Qualified dependents must be enrolled in your health care plan immediately prior to the actual qualifying event. Dependents who are dropped during Open Enrollment may not qualify for continued coverage under COBRA because dropping coverage during Open Enrollment does not constitute a COBRA-qualifying event. If you are dropping a dependent during Open Enrollment and you're not sure whether your dependent is eligible for COBRA due to a qualifying event, please contact the HR Service Center at the phone number shown on the inside back cover.

IMPORTANT: If you divorce, legally separate or dissolve a registered domestic partnership, or if a dependent child no longer qualifies as an eligible dependent under the plans, you must call the HR Service Center to request COBRA enrollment materials **within 60 days** of the COBRA-qualifying event or the last day of eligible coverage — whichever occurs last. An HR Service Center representative will give you a COBRA Notification Confirmation Number, which you should keep until you have received your COBRA enrollment materials. This number will serve as confirmation that you provided timely notification, as required by PG&E policy.

If you are an employee and die or lose health coverage through PG&E or another Participating Employer, Ceridian (the COBRA administrator) will automatically provide you or your dependents with COBRA enrollment materials. If you are a retiree and die, your dependent should contact the HR Service Center to request COBRA enrollment materials, if desired.

If Your COBRA HMO Coverage Ends

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

If you're an Anthem Blue Cross member and your COBRA coverage is ending, you may contact Anthem Blue Cross to request coverage under a HIPAA Guaranteed Issue plan. Contact Anthem Blue Cross at least 60 days before your COBRA coverage ends. The cost and coverage of any HIPAA Guaranteed Issue individual plan may vary considerably from your COBRA plan.

WOMEN’S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of 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 of the mastectomy, including lymphedemas.

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

NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

This notice is to remind you of the availability of the HIPAA Notice of Health Information Privacy Practices (“HIPAA Notice”) for The Pacific Gas and Electric Company Health Care Plan for Active Employees, The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, and The Pacific Gas and Electric Company Health Care Reimbursement Account Plan (“The Health Care Plans”). The HIPAA Notice was provided to you in the *Summary of Benefits Handbook* dated January 2008.

The HIPAA Notice is posted on the HR intranet site in the **Plans, Policies & Forms** section or is available upon request. It describes how personal health information about you on file with The Health Care Plans may be used and disclosed, as well as how you can access your personal health information. In general, your individual health information may be used and disclosed by The Health Care Plans for purposes of treatment, payment and operations, as well as other uses and disclosures allowed or required by law.

For more information about The Health Care Plans’ health information privacy practices or HIPAA rights, or if you or your eligible dependents have questions about the HIPAA Notice, contact the Pacific Gas and Electric Company Plan Administrator, Benefits Department, 1850 Gateway Boulevard, 7th Floor, Concord, CA 94520.

MEDICARE-ELIGIBLE PARTICIPANTS: IMPORTANT NOTICE FROM PACIFIC GAS AND ELECTRIC COMPANY ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage under plans sponsored by Pacific Gas and Electric Company (PG&E) and your options under Medicare's prescription drug coverage (called Part D). This information can help you decide if you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans also may offer more coverage for a higher monthly premium.
2. PG&E has determined that the prescription drug coverage offered by the Pacific Gas and Electric Company Health Care Plan for Active Employees and by the Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and you will not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15 through December 31.

However, if you decide to drop your PG&E coverage or if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Medicare Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

Prescription drug coverage is included in all PG&E-sponsored medical plans. Every medical plan that PG&E currently offers to Medicare-eligible participants has a higher prescription drug benefit than the basic Part D benefit.

If you decide to join a Medicare drug plan that is not sponsored by PG&E (a plan not offered through PG&E's Open Enrollment), your PG&E-sponsored medical and prescription drug benefits will be terminated.

Can You Re-Enroll in a PG&E-Sponsored Plan at a Later Date?

Eligible retirees, employees on long-term disability, and their dependents who join a Medicare drug plan that is not sponsored by PG&E will *not* be able to re-enroll in a PG&E-sponsored medical plan until the next Open Enrollment. Surviving dependents who join a non-PG&E Medicare drug plan will *not* be able to re-enroll in a PG&E-sponsored plan at any time.

PG&E-sponsored medical plans with prescription drug coverage and Medicare Advantage Plans are available during Open Enrollment for eligible retirees, surviving dependents and employees on long-term disability. For more information about these PG&E-sponsored plans, see the *2010 Benefits Enrollment Guide*.

When Will You Pay a Higher Premium (Penalty) to Join A Medicare Drug Plan?

If you drop or lose your PG&E-sponsored coverage and you don't join a Medicare drug plan within 63 continuous days after your PG&E-sponsored coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 days or longer without creditable prescription drug coverage, your monthly premium will go up by at least one percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

KEEP THIS NOTICE

Be sure to keep this Creditable Coverage notice. If you decide to join a non-PG&E-sponsored Medicare drug plan, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and therefore, whether or not you are required to pay a higher premium (a penalty).

WHERE TO FIND MORE INFORMATION

For more information about this notice or your current prescription drug coverage, contact the HR Service Center at the phone number shown on the inside back cover.

NOTE: You will receive this notice each year. You also will receive it before the next period during which you can join a Medicare drug plan, and if your coverage through PG&E changes. You may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You also may be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug plans:

- Visit *www.medicare.gov*
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for the telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users, call 877-486-2048

If you have limited income and resources, you may qualify for extra help paying for Medicare prescription drug coverage. For information about this extra help, visit the Social Security Administration (SSA) online at *www.socialsecurity.gov*, or call the SSA at 800-772-1213 (TTY 800-325-0778).

October 2009
Pacific Gas and Electric Company

HR Service Center
1850 Gateway Boulevard., 7th Floor
Concord, CA 94520

PG&E BENEFITS INFORMATION & CONTACTS

	PHONE	E-MAIL
Active Employees and Employees on Leave or Long-Term Disability	415-973-4357 or 800-788-2363	hrbenefitsquestions@exchange.pge.com
Retirees and Surviving Dependents	415-972-7077 or 800-700-0057	
Representatives are available Monday through Friday from 7:30 a.m. to 5 p.m. Pacific Time.		

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