Claims and Appeals Process for the Self-Funded Medical Plans Administered by UnitedHealthcare

Filing a Claim for Benefits

UnitedHealthcare is the claims administrator for the self-funded medical plans sponsored by PG&E. As the claims administrator, UnitedHealthcare contracts with a network of providers and processes claims. UnitedHealthcare pays network providers directly for your Covered Health Services. You are responsible for paying copayments and/or deductibles to the network provider at the time of service or when you receive a bill from the provider. If a network provider bills you for any Covered Health Service, contact UnitedHealthcare at 1-877-842-4373.

When you receive Covered Health Services from a non-network provider, you are responsible for paying the provider up front and filing a claim with UnitedHealthcare, even if your services were due to an emergency or because your network provider referred you to a non-network provider. You must file the claim in a format that contains all of the information required, as described below. Claim forms may be obtained by calling UnitedHealthcare at 1-877-842-4373.

You must file a claim for payment of benefits within two years of the date of service. If a non-network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If your claim relates to an inpatient hospital stay, the date of service is the date on which your inpatient stay ends. If you don't file a claim and provide all required information to UnitedHealthcare within two years of the date of service, benefits for that health service will be denied. This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of benefits from UnitedHealthcare, you must provide UnitedHealthcare with all of the following information:

A. The member's name and address.

B. The patient's name, age and relationship to the member.

C. The member {and Group} number stated on your ID card.

D. An itemized bill from your provider that includes the following:
   - Patient diagnosis
   - Date(s) of service
   - Procedure code(s) and descriptions of service(s) rendered
   - Charge for each service rendered
   - Provider name, address and Tax Identification Number (TIN)

E. The date the injury or sickness began.

F. A statement indicating whether or not you are enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

Send your claim to:

UnitedHealthcare
P.O. Box 30555
Salt Lake City, Utah 84130-0555

Payment of Benefits for Non-Network Benefits

UnitedHealthcare will make a benefit determination on non-network services as set forth below. Benefits will be paid directly to you unless either of the following is true:

- The provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to that provider; or
- You make a written request for the non-network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will not reimburse third parties who have purchased or been assigned benefits by physicians or other providers.

Benefit Determinations (Before an Appeal is Filed)

There are various types of benefits claims. Each benefit claim can be categorized as a post-service, pre-service, urgent or current claim. Depending on the type of claim, UnitedHealthcare must process your claim within different timeframes. The processing timeframes for each type of claim are explained below.

Post-Service Claims

- Post-service claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, UnitedHealthcare will send you a written notice in the form of an Explanation of Benefits within 30 days of receipt of the claim, provided that all required information was included with the claim. UnitedHealthcare will notify you within this 30-day period if additional information is needed to process your claim, and may request a one-time extension of no longer than 15 days and pend your claim until all required information is received.
- If notified that an extension is necessary due to incomplete claim information, you will have 45 days to provide the required information to UnitedHealthcare. If all of the required information is received within the 45-day timeframe and the claim is then denied, UnitedHealthcare will notify you of the denial within 15 days of receipt of the additional information. If you don't provide the needed information within the 45-day period, your claim will be denied.
- If your claim is denied, the denial notice – typically an Explanation of Benefits statement – will explain the reason(s) for the denial, refer to the Plan provision(s) on which the denial is based, and provide procedures on how to appeal the claim.

Pre-Service Claims

Pre-service claims are those claims for services that require notification or approval prior to receiving the services. Requests for pre-service claims that are not urgent must be submitted in

writing and sent to:

UnitedHealthcare
P.O. Box 30555
Salt Lake City, Utah 84130-0555

If your claim is a pre-service claim and was submitted properly with all the required information, UnitedHealthcare will send you written notice of its claim decision within 15 days of receipt of the claim. If you file a pre-service claim improperly, UnitedHealthcare will notify you that the claim was improperly filed within five days of receiving the pre-service claim and give you information on how to correct it. If additional information is needed to process the pre-service claim, UnitedHealthcare will notify you within 15 days of receipt of the claim that additional information is needed, and may request a one-time extension of no longer than 15 days and pend your claim until all required information is received.

If notified that an extension is necessary due to incomplete claim information, you will have 45 days to provide the required information to UnitedHealthcare. If all of the required information is received within the 45-day timeframe, UnitedHealthcare will notify you of its determination within 15 days of receipt of the additional information. If you don't provide the required information within the 45-day period, your claim will be denied.

If your claim is denied, the denial notice will explain the reason(s) for the denial, refer to the Plan provision(s) on which the denial is based, and provide procedures on how to appeal the claim.

Urgent Claims that Require Immediate Action

Urgent care claims are those claims (1) that require notification or approval prior to receiving medical care, and (2) where a delay in treatment could seriously jeopardize your life, health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain. In these situations, you may submit your request in writing to the address listed above or call UnitedHealthcare at 1-877-842-4743. After UnitedHealthcare receives the request, you will receive a response as follows:

- You will receive notice of the benefit determination in writing or electronically within 72-hours of UnitedHealthcare's receipt of all necessary information, taking into account the seriousness of your condition. Notice of denial may be oral with a written or electronic confirmation to follow within three days.
- If you file an urgent care claim improperly, UnitedHealthcare will notify you that the claim was improperly filed within 24 hours of receiving the urgent claim and give you information on how to correct it. If additional information is needed to process the claim, UnitedHealthcare will notify you of the information needed within 24 hours of receiving the claim. You will then have 48 hours to provide the requested information.

You will be notified of UnitedHealthcare's determination no later than 48 hours after:

- UnitedHealthcare's receipt of the requested information; or
- the end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

If your claim is denied, the notice of denial will explain the reason(s) for the denial, refer to the Plan provision(s) on which the denial is based, and provide procedures on how to appeal the claim.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined above, UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours of receiving your request, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Concurrent claims that are considered urgent may be submitted in writing or by calling UnitedHealthcare at 1-877-842-4743. Non-urgent claims must be submitted in writing and sent to:

UnitedHealthcare
P.O. Box 30555
Salt Lake City, Utah 84130-0555

To Resolve a Problem

UnitedHealthcare has established a complaint resolution and grievance process to resolve members' problems or complaints. If you or a covered dependent has a question, problem or complaint, you should call 1-877-842-4743 or write to the address below:

UnitedHealthcare
P.O. Box 30555
Salt Lake City, Utah 84130-0555

If your question or concern is about a benefit determination, you should typically contact Member Services before filing a formal appeal. If the Member Services representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing or file an appeal. If you wish to file an appeal, you should contact Customer Service again and state that you would like to file an appeal. You may also send your written appeal to the address above.

If you are appealing an urgent care claim denial, please refer to the ***Urgent Claim Appeals that Require Immediate Action*** section on page 6 and contact Member Services at 1-877-842-4743 immediately. The Member Services telephone number is also shown on your ID card. Member Services representatives are available to take your call during regular business hours, Monday through Friday.

Appeals

How to Appeal a Claim Decision – Non-Urgent

If you still disagree with a claim determination after following the above steps, you can contact UnitedHealthcare in writing to formally appeal the claim. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from your ID card

- The date(s) of medical service(s)
- The provider's name
- The reason you believe the claim should be paid
- Any documentation or other written information to support your request for claim payment

Send your appeal to:

UnitedHealthcare
Attention: Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-432

Your first request to appeal the claim must be submitted to UnitedHealthcare **within 180 days** of your receipt of the claim denial.

Appeal Process

UnitedHealthcare provides two levels of appeals for each claim. In each appeal step, a qualified individual who was not involved in an earlier denial of your claim will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be conducted by a health care professional that has appropriate expertise and was not involved in any prior determination. UnitedHealthcare may consult with, or seek the participation of, medical experts as part of the appeal resolution process. If applicable, you must consent to this referral and the sharing of pertinent medical claim information to continue the appeal process. You may request, at no cost, to have access to and copies of all documents, records, and other information relevant to your claim for benefits.

To initiate a second appeal, you must follow the same steps as outlined above in ***How to Appeal a Claim Decision – Non-Urgent*** or as described under ***Urgent Claim Appeals that Require Immediate Action*** on page 6. Your second-level appeal request must be submitted to UnitedHealthcare **within 60** days of your receipt of UnitedHealthcare's first-level appeal decision.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of UnitedHealthcare's decision on your appeal as follows:

- For appeals of **pre-service claims,** UnitedHealthcare will conduct the first-level review and notify you of its decision within 15 days of receipt of your request to appeal the denied claim. If you request a second-level appeal review, UnitedHealthcare will also conduct this review and notify you of its decision within 15 days of receipt of your request for a second-level appeal review.
- For appeals of **post-service claims**, UnitedHealthcare will conduct the first-level review and notify you of its decision within 30 days of receipt of your request to appeal the denied claim. If you request a second-level appeal review, UnitedHealthcare will also conduct this review and will notify you of its decision within 30 days from receipt of your request for a second-level appeal review.

Please note that UnitedHealthcare's decision is based only on whether or not benefits are Covered Health Services as defined by the appropriate medical plan. The determination as to whether the health service is necessary or appropriate is between you and your physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- Your appeal does not need to be submitted in writing. You or your physician should call UnitedHealthcare at 1-877-842-4373 as soon as possible. UnitedHealthcare will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

If you are not satisfied with the claims and appeals review completed with UnitedHealthcare, you can bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") or use PG&E's Voluntary Review Process (see below). However, before you can take civil action, you must go through both levels of appeal provided by UnitedHealthcare.

PG&E's Voluntary Review Process

If you are not satisfied with the claims and appeals process completed with UnitedHealthcare, you may elect to either bring civil action or use PG&E's Voluntary Review Process. You have 90 days from the date of receipt of the final decision from UnitedHealthcare to elect this voluntary review. Initiation of the Voluntary Review Process does not restrict your ability to bring an ERISA action against the Plan.

Step 1:

The first step of the Voluntary Review Process is to write to the Benefits Department, requesting a review your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include a Release of Confidentiality. This may be obtained from PG&E's intranet at wwwhr or by calling the HR Service Center at the appropriate phone number listed on page 7. You should send your appeal to:

Pacific Gas and Electric Company
Benefits Department, Mail Code N2P
Appeals
P.O. Box 770000
San Francisco, CA 94177

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the Release of Confidentiality may delay your appeal). There may be special circumstances where an extension of up to 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial;
- a reference to the plan provision(s) that apply to the denial; and
- an explanation of additional appeals procedures.

If your claim deals with specific medical issues, the Benefits Department may suggest that your claim be submitted to an External Review Program as part of the first step of the Voluntary Review Program. The External Review Program entails having an independent third party review the claim in question. This program only applies if the decision is based on either of the following:

- clinical reasons such as previous denials for custodial care or cosmetic services; or
- the exclusions for Experimental, Investigational or Unproven Services.

The External Review Program is not available if the coverage determinations are based on explicit benefit exclusions or defined benefit limits. The External Review Program is optional, and its costs are paid by the Plan. If the External Review Program recommends that the claim be covered, the Benefits Department will abide by the recommendation of the External Review Program.

Step 2:

The second step of the Voluntary Review Process is to submit your appeal to an independent neutral third party for review. The third-party reviewer will be selected from a predetermined panel of arbitrators familiar with benefits law. You have the option of submitting the same written appeal prepared for Step One or may choose to supplement the Step One write-up with additional written material. The neutral third party will issue a written decision within 45 days of receipt of the appeals documentation. The neutral third party's decision shall be final and binding on the Company, but not on you.

You have 60 days to exercise the second step of appeal. Send your written appeal with any additional information to:

Pacific Gas and Electric Company
Benefits Department, Mail Code N2P
Appeals – Step Two
P.O. Box 770000
San Francisco, CA 94177

If you would like more information regarding the Voluntary Review Process, you can write to the Benefits Department or call the HR Service Center at the appropriate number listed below.

HR Service Center

Active Employees: Company extension 223-2363, 415-973-2363 or 1-800-788-2363
Retirees and Surviving Dependents: 1-800-700-0057

Claims and Appeals Process for the Mental Health, Alcohol and Drug Care Program

ValueOptions is the claims administrator for the Mental Health, Alcohol and Drug Care program. As the claims administrator, ValueOptions contracts with a network of providers and facilities and processes claims for services.

If you use a network provider or facility, the provider will send the claim directly to ValueOptions for payment. Claim forms are available by calling ValueOptions at 1-800-562-3588.

If you use a non-network provider, you must submit a claim form to ValueOptions. Claims must be submitted within two years of the date of service.

Inquiries, Benefit Certifications, and Claims

If you have a question, an issue or complaint regarding your Mental Health, Alcohol and Drug Care Program benefits, you should contact ValueOptions at 1-800-562-3588. Many problems, complaints or potential claim issues can be resolved informally.

Most requests for services and inquiries can be handled over the telephone. If you wish to find a network provider, you may call ValueOptions at 1-800-562-3588. If you would like to receive a benefits certification, which is a pre-approval of coverage for services, you or your provider should also call 1-800-562-3588. Generally, a determination of your benefit request will be made by the end of the telephone conversation and will be confirmed with a written notification from ValueOptions. If the benefit certification cannot be made at the time of the phone call, you will receive a written notification from ValueOptions of the decision. The type of benefit certification requested will determine the timeframe for the receipt of notification.

The processing timeframes for receipt of benefit certifications are as follows:

- **Urgent care** – where a delay in treatment could jeopardize your life or health – within 72 hours of receipt of your request

- **Non-urgent** – a request for services that require pre-authorization -- within five days of receipt of your request

- **Concurrent care** – a request for continuation of current treatment -- within one day for urgent requests, four days for non-urgent requests

For urgent care and urgent concurrent care certifications, notification by telephone will be made to your provider at the time of the determination, along with written notification to you and your provider.

If have questions regarding a claim for non-network services, you should also call ValueOptions at the number above. If you submit a claim for services received, ValueOptions will process your claim and notify you of its disposition within 30 days of receipt.

Appeals

Pre-Service Appeals-Non Urgent

If you are not satisfied with ValueOptions' initial claim or benefit certification resolution or you believe you have received some other type of adverse benefit determination that is preventing you from receiving the services you requested in the process of trying to obtain a benefits certification, you can appeal the benefit denial/determination within 180 days of receipt of the denial or adverse determination. Your appeal may be made in writing or by calling ValueOptions at 1-800-562-3588. If you submit your appeal in writing, you must include the following information: your name, member ID, phone number, the service for which benefit coverage has been denied, and any additional information that may be relevant to your appeal. The appeal should be sent to:

ValueOptions
Attention: Appeals
340 Golden Shore
Long Beach, CA 90802

ValueOptions will mail you a decision notice within 15 days of receipt of your appeal. The notice will include the specific reason(s) for the decision and the plan provision(s) on which the decision was based. You have the right to receive, upon request only and at no charge, the information used by ValueOptions to review your appeal.

If you are not satisfied with ValueOptions' decision, you have 90 days from the date of your receipt of the decision notice to request a second level of appeal. To initiate a second level of appeal, you can submit the appeal in writing by sending it to the above address or you can call ValueOptions at 1-800-562-3588. A professional committee composed of two or more members who were not involved with the initial decision will conduct the review. The decision regarding your request will be sent to you within 15 days of its receipt. If at this point your appeal is denied, you can bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") or initiate PG&E's Voluntary Review Process, as described on page 11.

Pre-Service Appeal – Urgent

If your appeal for coverage involves urgent care, you can request an expedited review by telephoning or writing to ValueOptions. You will be notified of the benefit determination within 72 hours of ValueOptions' receipt of the appeal. A Medical Department representative will contact your provider to schedule a time for a telephone review of your case. Your provider will be advised of the determination at the end of the telephone review. A written notification of the decision will be sent to you and your provider within three days of your request. If you or your provider has additional information to be included in the appeal, you will need to provide the additional information within three days of the appeal request.

An urgent appeal is any claim for treatment with respect to which the application of the time periods for a non-urgent care determination could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function or, in the opinion of a physician

with knowledge of the claimant's medical condition, could subject the claimant to severe pain that cannot be adequately managed.

If you receive an adverse benefit determination on your appeal, you have the right to further appeal the decision. You have 90 days to request a second level of appeal. A professional committee composed of two or more members who were not involved with the initial decision will conduct the review. A benefit determination will be sent to you and your provider within 72 hours of your request. You may submit the appeal in writing or by calling ValueOptions at 1-800-562-3588. The appeal should be sent to:

ValueOptions
Attention: Appeals
340 Golden Shore
Long Beach, CA 90802

If at this point your appeal is denied, you can bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") or initiate PG&E's Voluntary Review Process, as described on page 11.

Post-Service Claims Appeals

If you believe that your claims were processed or denied incorrectly, you can try to resolve the issue informally as described in the ***Inquires, Benefit Certifications, and Claims*** section on page 8. If this approach is unsatisfactory, you may appeal the initial claim determination. To initiate an appeal, you must write or telephone ValueOptions (1-800-562-3588) within 180 days of receipt of the claim processing determination. Your appeal must include the following information: your name, member ID, phone number, a copy of the denied or incorrectly processed claim and any additional information that may be relevant to your appeal. Written appeals should be sent to:

ValueOptions
Attention: Appeals
340 Golden Shore
Long Beach, CA 90802

A decision notice will be mailed to you within 30 days of receipt of your appeal. The notice will include the specific reason(s) for the decision and a reference to the plan provision(s) on which the decision was based. You also have the right to receive, only upon request and at no charge, the information that ValueOptions used to review your appeal. If the information you submit with your appeal is incomplete, you will be notified by letter of the additional information needed. If you do not send the information within 45 days of the date on which you received the letter, the case will be closed.

If you are not satisfied with the decision, you have 90 days from the date of your receipt of the notice to request a second level of appeal. To initiate a second level of appeal, you can submit your request in writing to the above address or you can call ValueOptions at 1-800-562-3588. A qualified individual who was not involved in your original appeal will review your appeal. A decision will be made regarding your request and will be sent to you within 30 days of ValueOptions' receipt of your appeal.

If at this point your appeal is denied, you can bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (“ERISA”) or initiate PG&E’s Voluntary Review Process, as described on below.

PG&E’s Voluntary Review Process

If you are not satisfied with the claims and appeals process completed with ValueOptions, you may elect to either bring a civil action under ERISA or use PG&E’s Voluntary Review Process. You have 90 days from the date of your receipt of the final decision from ValueOptions to elect this voluntary review. Initiation of the Voluntary Review Process does not restrict your ability to bring an ERISA action against the Plan.

Step 1:

The first step of the Voluntary Review Process is to write to the Benefits Department, requesting a review your appeal. Your appeal should include all pertinent documentation. You should send your appeal to:

Pacific Gas and Electric Company
Benefits Department, Mail Code N2P
P.O. Box 770000
San Francisco, CA 94177

The Benefits Department will review your appeal and typically will make a decision within 60 days of the date on which a complete appeal request is received. The Company may need to receive a confidentiality release signed by you in order to review your appeal. If there are special circumstances, the Benefits Department will notify you that an extension of up to 90 days will be required. If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial
- a reference to the plan provision(s) that apply to the denial; and
- an explanation of additional appeals procedures

If your claim deals with specific medical issues, the Benefits Department may suggest that your claim be submitted to an External Review Program as part of the first step of the Voluntary Review Process. The External Review Program entails having an independent third party review the claim in question. This program only applies if the decision is based on either of the following:

- Clinical reasons such as previous denials for custodial care or cosmetic services, or
- The exclusion for Experimental, Investigational or Unproven Services.

The External Review Program is not available if the coverage determinations are based on explicit benefit exclusions or defined benefit limits. The External Review Program is optional, and its costs are paid by the Plan. If the External Review Program recommends that the claim be covered, the Benefits Department will abide by the recommendation of the External Review Program.

Step 2:

The second step of the Voluntary Review Process is to submit your appeal to an independent neutral third party for review. The third-party reviewer will be selected from a predetermined panel of arbitrators familiar with benefits law. You have the option of submitting the same written appeal prepared for Step One or may choose to supplement the Step One write-up with additional written material. The neutral third party will issue a written decision within 45 days of receipt of the appeals documentation. The neutral third party's decision shall be final and binding on the Company, but not on you.

You have 60 days to initiate the second step of appeal. Send your written appeal with any additional information to:

Pacific Gas and Electric Company
Benefits Department, Mail Code N2P
P.O. Box 770000
San Francisco, CA 94177

If you would like more information regarding the Voluntary Review Process, you can write to the Benefits Department or call the HR Service Center at the appropriate number listed below.

HR Service Center

Active Employees: Company extension 223-2363, 415-973-2363 or 1-800-788-2363
Retirees and Surviving Dependents: 1-800-700-0057

CLAIMS and APPEALS PROCEDURE for the PRESCRIPTION DRUG PLAN

Medco Health is the claims administrator for the Prescription Drug Plan. Medco Health has a network of pharmacies that provide retail coverage, and Medco Health sponsors home delivery prescription drug coverage. When you go to a participating retail pharmacy, simply present your identification card and pay the appropriate coinsurance.

If you use a non-participating pharmacy, you will be responsible for paying the full cost of the prescription to the pharmacist, and then filing a claim for reimbursement. Claim forms are available by calling Medco Health at 1-800-718-6590. You must submit your claim within 12 months of the date on which you received your prescription. If you do not file a claim within this timeframe, your claim will be denied.

Claims and Inquires

If you have an issue or complaint regarding your prescription drug benefits, you should first address your concerns with Medco Health within 60 days after the issue or complaint arises. Many problems, complaints, and potential claims issues can be resolved informally. You can address these informal complaints by phoning Medco Health at 1-800-718-6590. Medco Health may ask you to provide additional information or ask your physician to do so, or may try to clarify any information already provided. Medco Health will research your issue and respond to you on its findings either in writing or by telephone within 15 days for prescriptions that have not been filled, and within 30 days for prescriptions that have already been filled and paid for.

Appeals

Pre-Service Denials (Cannot Get the Prescription Filled) – Non-Urgent

If a pharmacist will not fill your prescription and your situation is not urgent, it is recommended that you first try to resolve the situation informally as described above. However, if you are not satisfied with the initial resolution or you believe that you have received some type of adverse benefit determination that is preventing you from filling a prescription, you or your authorized representative (such as your physician) can appeal the benefit denial/determination in writing within 180 days of receipt of the denial or adverse determination. Your appeal must be in writing and must include the following information: your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, and any additional information that may be relevant to your appeal. The appeal should be sent to:

Medco Health Solutions
Attention: Coverage Reviews
8111 Royal Ridge Parkway
Irving, Texas 75063

A decision notice will be mailed to you within 15 days of receipt of your appeal. The notice will include the specific reason(s) for the decision and the plan provision(s) on which the decision was based. You have the right to receive, upon request only and at no charge, the information used to review your appeal.

If you are not satisfied with Medco Health's decision, you have 90 days from the date of your receipt of the decision notice to request a second level of appeal. To initiate a second level of appeal, you must submit the appeal in writing to the address above. A decision will made regarding your request and will be sent to you within 15 days of Medco Health's receipt of the request. A qualified individual who was not involved in your original appeal will review your appeal. If at this point your appeal is denied, you can bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") or initiate PG&E's Voluntary Review Process, as described on page 15.

Pre-Service Appeal – Urgent

If a pharmacist will not fill your prescription as desired and your situation is urgent, you may request an expedited review by calling Medco Health at 1-800-753-2851. In cases of an appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of Medco Health's receipt of the appeal. An urgent appeal is any claim for treatment with respect to which the application of the time periods for a non-urgent care determination could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, could subject the claimant to severe pain that cannot be adequately managed. You or your physician may submit an urgent appeal by phone or in writing. If the appeal does not contain sufficient information to determine whether benefits are covered, you will be notified of the missing information within 24 hours of Medco Health's receipt of your appeal. You will than have 48 hours to provide the missing information to Medco Health and will be notified by phone or in writing of Medco Health's decision within 48 hours of receipt of the information. All written appeals must be sent to:

MCMC LLC
c/o Medco Health Solutions
Attention: Coverage Reviews
8111 Royal Ridge Parkway
Irving, Texas 75063

If at this point your appeal is denied, you have the right to bring a civil action under Section 502(a) of ERISA or you can initiate PG&E's Voluntary Review Process, as described on page 15.

Post-Service Appeals

If you paid for your prescription and believe that your level of coverage was incorrect, you can try to resolve this issue informally, as described in the ***Claims and Inquires*** section on page 13. If this approach is unsatisfactory, you or an authorized representative, such as your physician, may appeal the decision in writing within 180 days of your receipt of the claim processing determination (e.g., pharmacy receipt). Your appeal must be in writing and must include the following information: your name, member ID, phone number, the prescription drug for which the level of coverage appears incorrect, and any additional information that may be relevant to your appeal. The appeal should be sent to:

Medco Health Solutions
Attention: Coverage Reviews
8111 Royal Ridge Parkway
Irving, Texas 75063

A decision notice will be mailed to you within 30 days of Medco Health's receipt of your appeal. The notice will include the specific reason(s) for the decision and a reference to the plan provision(s) on which the decision was based. You also have the right to receive, only upon request and at no charge, the information that Medco Health used to review your appeal.

If you are not satisfied with the decision, you have 90 days from the date of your receipt of the notice to request a second level of appeal. To initiate a second level of appeal, you must submit the appeal in writing to the above address. A qualified individual who was not involved in your original appeal will review your second appeal. A decision will be made regarding your request and will be sent to you within 30 days of Medco Health's receipt of your appeal. Medco Health's decisions are based only on whether or not a benefit is covered by the Plan.

If at this point your appeal is denied, you can bring a civil action under Section 502(a) of ERISA or initiate PG&E's Voluntary Review Process, as described below.

PG&E's Voluntary Review Process

If you are not satisfied with the claims and appeals process completed with Medco Health, you may elect to either bring civil action or use PG&E's Voluntary Review Process. You have 90 days from the date on which you receive a final decision from Medco Health to elect this voluntary review. Initiation of the Voluntary Review Process does not restrict your ability to bring an ERISA action against the Plan.

The first step of the Voluntary Review Process is to write to the Benefits Department for a review of your appeal. You should include all relevant information in your appeal. To expedite processing, you should also include a Release of Confidentiality. This may be obtained from PG&E's intranet at wwwhr or by calling the HR Service Center at Company extension 223-2363, 415-973-2363 or 1-800-788-2363. Send the appeal to:

Pacific Gas and Electric Company
Benefits Department, Mail Code N2P
Appeals
P.O. Box 770000
San Francisco, CA 94177

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the Release of Confidentiality may delay your appeal). There may be special circumstances where an extension of up to 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial;
- a reference to the plan provision(s) that apply to the denial; and
- an explanation of additional appeals procedures.

You may then have your appeal reviewed by the Employee Benefit Administrative Committee (EBAC). You must submit a new appeal in writing stating the reason(s) for your appeal and enclosing all relevant documentation and information that supports your appeal. Unless there are

special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal. Send the appeal to:

Pacific Gas and Electric Company
Benefits Department – EBAC, Mail Code N2P
P.O. Box 770000
San Francisco, CA 94177

Aetna HMO

This information along with your health plan's Evidence of Coverage represents an update to your *Summary of Benefits Handbook*.

Deductible Requirements
Not applicable

Inpatient Hospital – Room and Board, Anesthesia, Surgery, Other Services (incl. Ambulance)
No charge to members

Skilled Nursing Facility
No charge to members

Outpatient Hospital and Surgery
Members pay $5 per visit if surgery is in physician's office; no charge if in hospital

Emergency Room Care
Members pay $25 per visit; waived if admitted as inpatient

Doctor Visits
Members pay $5 per office visit; members pay $10 per home visit when medically necessary

Preventive Health Care including Routine Physicals and Well-Baby Care
Members pay $5 per visit including well-baby care.
Maternity care, members pay $5 first visit only.

Outpatient X-rays and Lab Tests
Member pays $5 if rendered at a facility; otherwise, included in office visit copayment

Pre-Admission Testing
No charge to members

Home Health Care and Hospice Care
No charge to members

Outpatient Physical Therapy
Members pay $5 per visit up to 60 consecutive days per condition

Outpatient Prescription Drugs
At retail pharmacy, members pay $10 copayment per generic formulary drug, $15 copayment per brand formulary drug, and $30 copayment per non-formulary drug for 30-day supply at participating pharmacy; no annual maximum. For mail-order drugs, members pay two times retail copayment for 31-90 day supply.

Prosthetics and Durable Medical Equipment
No charge to members

Mental Health – Outpatient
For severe mental illness, members pay $5 per visit; no visit limit. For other mental illnesses, members pay $25 per visit up to a 20-visit maximum per calendar year.

Mental Health – Inpatient
For severe mental illness, no charge to members; no day limit. For other mental illnesses, no charge for up to 30 days per calendar year.

Alcohol and Drug Care – No charge to members for inpatient detoxification. Members pay $5 per visit for up to 20 outpatient visits per calendar year. Also covered under separate PG&E Alcohol and Drug Care Program with referral by ValueOptions.

Eligible Dependents and Member Rights
See your PG&E Summary of Benefits Handbook for a complete description of eligibility, COBRA rights, Qualified Medical Child Support Order procedures and rights, ERISA rights and information, plan funding and plan continuation provisions.

Choice of Providers
Members must select a contracting Physician Group where the member wants to receive medical care. That Physician Group will provide or authorize all medical care. Family members may select different contracting Physician Groups. However, each person must select a contracting Physician Group close enough to his or her residence to allow reasonable access to medical care. In addition to selecting a contracting Physician Group, each member must choose a Primary Care Physician from the Physician Group. The Primary Care Physician provides and coordinates medical care. Providers are neither employed nor exclusively contracted by the HMO.

Plan Telephone Number: 1-800-756-7039

Web Site: www.aetna.com

- This benefit chart is a summary only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your Aetna Evidence of Coverage. The Evidence of Coverage is the binding document between Aetna HMO and its members.
- If you enroll in Aetna HMO, you will receive an Evidence of Coverage, free of charge. It describes Aetna's HMO benefit provisions, claims procedures, provider network information and other rules in detail. If you need additional information, including a list of participating network providers, you can contact Aetna HMO directly. You may also contact the HR Service Center at 415-973-2363 (Co. extension 223-2363) or 1-800-788-2363, which will forward your request for additional information to Aetna HMO.

Your Cost
Your cost is dependent on your retiree, bargaining unit or Flex employee status. Refer to your 2003 Enrollment Guide that you received in Fall 2002, call the HR Service Center or visit the Company's intranet site at wwwhr.

Important Note: The information contained in this summary is informational. No right shall accrue to you and/or your dependents because of any statement of error, or in omission from, this summary. Your health plan's Evidence of Coverage (EOC) is the binding document between the health plan and its members.

*Health Net HMO

*Includes Health Net Medicare Supplemental Plan

This information along with your health plan's Evidence of Coverage represents an update to your *Summary of Benefits Handbook*.

Deductible Requirements
Not applicable

Inpatient Hospital – Room and Board, Anesthesia, Surgery, Other Services (incl. Ambulance)
No charge to members

Skilled Nursing Facility
No charge to members; 100 days per calendar.

Outpatient Hospital and Surgery
Members pay $5 per visit if surgery is in physician's office; no charge if in hospital

Emergency Room Care
Members pay $25 per visit; waived if admitted as inpatient

Doctor Visits
Members pay $5 per office visit; members pay $5 per home visit when medically necessary

Preventive Health Care including Routine Physicals and Well-Baby Care
Members pay $5 per visit including well-baby and maternity care.

Outpatient X-rays and Lab Tests
No charge to members

Pre-Admission Testing
No charge to members

Home Health Care and Hospice Care
No charge to members

Outpatient Physical Therapy
No charge to members as long as medically necessary

Outpatient Prescription Drugs
At retail pharmacy, members pay $5 copayment per generic formulary drug, $15 copayment per brand formulary drug, and $25 copayment per non-formulary drug for 30-day supply at participating pharmacy; no annual maximum. For mail-order drugs, members pay two times retail copayment for up to a 90-day supply.

Prosthetics and Durable Medical Equipment
No charge to members

Mental Health – Outpatient
For severe mental illness, members pay $5 per visit; no visit limit. For other mental illnesses, members pay $20 per visit up to a 20-visit maximum per calendar year.

Mental Health – Inpatient
For severe mental illness, no charge to members; no day limit. For other mental illnesses, no charge for up to 30 days per calendar year.

Alcohol and Drug Care – No charge to members for inpatient detoxification. Members pay $20 per visit for up to 20 outpatient visits per calendar year. Also covered under separate PG&E Alcohol and Drug Care Program with referral by ValueOptions.

Eligible Dependents and Member Rights
See your PG&E Summary of Benefits Handbook for a complete description of eligibility, COBRA rights, Qualified Medical Child Support Order procedures and rights, ERISA rights and information, plan funding and plan continuation provisions.

Choice of Providers
Members must select a contracting Physician Group where the member wants to receive medical care. That Physician Group will provide or authorize all medical care. Family members may select different contracting Physician Groups. However, each person must select a contracting Physician Group close enough to his or her residence to allow reasonable access to medical care. In addition to selecting a contracting Physician Group, each member must choose a Primary Care Physician from the Physician Group. The Primary Care Physician provides and coordinates medical care. Providers are neither employed nor exclusively contracted by the HMO.

Plan Telephone Number: 1-800-522-0088

Web Site: www.healthnet.com

- This benefit chart is a summary only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your Health Net Evidence of Coverage. The Evidence of Coverage is the binding document between Health Net HMO and its members.
- If you enroll in Health Net, you will receive an Evidence of Coverage, free of charge. It describes Health Net's benefit provisions, claims procedures, provider network information and other rules in detail. If you need additional information including a list of participating network providers, you can contact Health Net directly. You may also contact the HR Service Center at 415-973-2363 (Company extension 223-2363) or 1-800-788-2363, which will forward your request for additional information to Health Net.

Your Cost
Your cost is dependent on your retiree, bargaining unit or Flex employee status. Refer to your 2003 Enrollment Guide that you received in Fall 2002, call the HR Service Center or visit the Company's intranet site at wwwhr.

Important Note: The information contained in this summary is informational. No right shall accrue to you and/or your dependents because of any statement of error, or in omission from, this summary. Your health plan's Evidence of Coverage (EOC) is the binding document between the health plan and its members.

Kaiser Permanente North HMO

This information along with your health plan's Evidence of Coverage represents an update to your *Summary of Benefits Handbook*.

Deductible Requirements
Not applicable

Inpatient Hospital – Room and Board, Anesthesia, Surgery, Other Services (incl. Ambulance)
No charge to members

Skilled Nursing Facility
No charge to members up to 100 days when prescribed by plan physician. Skilled nursing facilities must be within the Kaiser Permanente service area.

Outpatient Hospital and Surgery
Members pay $5 per visit if surgery is in physician's office; no charge if in hospital

Emergency Room Care
Members pay $5 per visit; waived if admitted as inpatient

Doctor Visits
Members pay $5 per office visit; no charge for home visit when medically necessary

Preventive Health Care including Routine Physicals and Well-Baby Care
Members pay $5 per visit including well-baby care. No charge for maternity care.

Outpatient X-rays and Lab Tests
No charge to members

Pre-admission Testing
No charge to members

Home Health Care and Hospice Care
No charge to members living in service area when prescribed by plan physician.

Outpatient Physical Therapy
Members pay $5 per visit for two-month period; another two-month period may be prescribed if potential exists for significant improvement.

Outpatient Prescription Drugs
Members pay $10 per fill for up to a 100-day supply when obtained at plan pharmacy or through the plan's mail-order; only formulary drugs.

Prosthetics and Durable Medical Equipment
No charge to members

Alcohol and Drug Care
Inpatient – detoxification only, no charge; Outpatient – members pay $5 per individual visit or $2 per group visit.

Mental Health – Outpatient
For severe mental illness, members pay $5 per visit; no visit limit. For other mental illnesses, members pay $5 per visit up to a 20-visit maximum per calendar year.

Mental Health – Inpatient
For severe mental illness, no charge to members; no day limit. For other mental illnesses, no charge for up to 30 days per calendar year.

Eligible Dependents and Member Rights
See your PG&E Summary of Benefits Handbook for a complete description of eligibility, COBRA rights, Qualified Medical Child Support Order procedures and rights, ERISA rights and information, plan funding and plan continuation provisions.

Choice of Providers
Members must use Kaiser Permanente facilities and physicians, except for emergencies or as noted in the Evidence of Coverage. A Kaiser Permanente physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat a member's medical condition. The services and supplies must be provided, prescribed, authorized or directed by a Kaiser Permanente physician. Members may choose a primary care physician.

Plan Telephone Number: 1-800-464-4000

Web Site: www.kaiserpermanente.org/california

- This benefit chart is a summary only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your Kaiser Permanente Evidence of Coverage. The Evidence of Coverage is the binding document between Kaiser Permanente HMO and its members.
- If you enroll in Kaiser Permanente, you can request an Evidence of Coverage from Kaiser Permanente, free of charge. It describes Kaiser Permanente's benefit provisions, claims procedures, provider and facility information and other rules in detail. If you need additional information, including a list of participating network providers, you can contact Kaiser Permanente directly. You may also contact the HR Service Center at 415-973-2363 (Co. extension 223-2363) or 1-800-788-2363, which will forward your request for additional information to Kaiser Permanente.

Your Cost
Your cost is dependent on your retiree, bargaining unit or Flex employee status. Refer to your 2003 Enrollment Guide that you received in Fall 2002, call the HR Service Center or visit the Company's intranet site at wwwhr.

Important Note: The information contained in this summary is informational. No right shall accrue to you and/or your dependents because of any statement of error, or in omission from, this summary. Your health plan's Evidence of Coverage (EOC) is the binding document between the health plan and its members.

Kaiser Permanente South HMO

This information along with your health plan's Evidence of Coverage represents an update to your *Summary of Benefits Handbook*.

Deductible Requirements
Not applicable

Inpatient Hospital – Room and Board, Anesthesia, Surgery, Other Services (incl. Ambulance)
No charge to members

Skilled Nursing Facility
No charge to members up to 100 days when prescribed by plan physician. Skilled nursing facilities must be within Kaiser Permanente service area.

Outpatient Hospital and Surgery
Members pay $5 per visit if surgery is in physician's office; no charge if in hospital

Emergency Room Care
Members pay $5 per visit; waived if admitted as inpatient

Doctor Visits
Members pay $5 per office visit; no charge for home visit when medically necessary

Preventive Health Care including Routine Physicals and Well-Baby Care
Members pay $5 per visit including well-baby care. No charge for maternity care.

Outpatient X-rays and Lab Tests
No charge to members

Pre-Admission Testing
No charge to members

Home Health Care and Hospice Care
No charge to members living in service area when prescribed by plan physician.

Outpatient Physical Therapy
Members pay $5 per visit for two-month period; another two-month period may be prescribed if potential exists for significant improvement.

Outpatient Prescription Drugs
Members pay $5 per fill for up to a 100-day supply when obtained at plan pharmacy or through plan's mail-order; only formulary drugs.

Prosthetics and Durable Medical Equipment
No charge to members

Alcohol and Drug Care
Inpatient – detoxification only; Outpatient – members pay $5 per individual visit or $2 per group visit

Mental Health – Outpatient
For severe mental illness, members pay $5 per visit; no visit limit. For other mental illnesses, members pay $5 per visit up to a 20-visit maximum per calendar year.

Mental Health – Inpatient
For severe mental illness, no charge to members; no day limit. For other mental illnesses, no charge for up to 30 days per calendar year.

Eligible Dependents and Member Rights
See your PG&E Summary of Benefits Handbook for a complete description of eligibility, COBRA rights, Qualified Medical Child Support Order procedures and rights, ERISA rights and information, plan funding and plan continuation provisions.

Choice of Providers
Members must use Kaiser Permanente facilities and physicians, except for emergencies or as noted in the Evidence of Coverage. A Kaiser Permanente physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat a member's medical condition. The services and supplies must be provided, prescribed, authorized or directed by a Kaiser Permanente physician. Members may choose a primary care physician.

Plan Telephone Number: 1-800-464-4000

Web Site: www.kaiserpermanente.org/california

- This benefit chart is a summary only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your Kaiser Permanente Evidence of Coverage. The Evidence of Coverage is the binding document between Kaiser Permanente HMO and its members.
- If you enroll in Kaiser Permanente, you will receive an Evidence of Coverage, free of charge. It describes Kaiser Permanente's benefit provisions, claims procedures, provider and facility information and other rules in detail. If you need additional information, including a list of participating network providers, you can contact Kaiser Permanente directly. You may also contact the HR Service Center at 415-973-2363 (Company extension 223-2363) or 1-800-788-2363, which will forward your request for additional information to Kaiser Permanente.

Your Cost
Your cost is dependent on your retiree, bargaining unit or Flex employee status. Refer to your 2003 Enrollment Guide that you received in Fall 2002, call the HR Service Center or visit the Company's intranet site at wwwhr.

Important Note: The information contained in this summary is informational. No right shall accrue to you and/or your dependents because of any statement of error, or in omission from, this summary. Your health plan's Evidence of Coverage (EOC) is the binding document between the health plan and its members.

PacifiCare HMO

This information along with your health plan's Evidence of Coverage represents an update to your *Summary of Benefits Handbook*.

Deductible Requirements
Not applicable

Inpatient Hospital – Room and Board, Anesthesia, Surgery, Other Services (incl. Ambulance)
No charge to members

Skilled Nursing Facility
No charge to members; 100 days per calendar year from first treatment, per disability.

Outpatient Hospital and Surgery
Members pay $5 per visit if surgery is in physician's office; no charge if in hospital

Emergency Room Care
Members pay $25 per visit; waived if admitted as inpatient

Doctor Visits
Members pay $5 per office visit; members pay $5 per home visit when medically necessary

Preventive Health Care including Routine Physicals and Well-Baby Care
Members pay $5 per visit including well-baby care. No charge to members for maternity care.

Outpatient X-rays and Lab Tests
No charge to members

Pre-Admission Testing
No charge to members

Home Health Care and Hospice Care
No charge to members; hospice care limited to 180 days per lifetime

Outpatient Physical Therapy
Members pay $5 per visit as long as medically necessary

Outpatient Prescription Drugs
At retail pharmacy, members pay $5 copayment per generic formulary drug, $15 copayment per brand formulary drug, and $25 copayment per non-formulary drug for 30-day supply at participating pharmacy; no annual maximum. For mail-order drugs, members pay two times retail copayment for up to a 90-day supply.

Prosthetics and Durable Medical Equipment
No charge to members

Mental Health – Outpatient
For severe mental illness, members pay $5 per visit; no visit limit. For other mental illnesses, members pay $20 per visit up to a 20-visit maximum per calendar year.

Mental Health – Inpatient
For severe mental illness, no charge to members; no day limit. For other mental illnesses, no charge for up to 30 days per calendar year.

Alcohol and Drug Care – No charge to members for inpatient detoxification. Members pay $5 per visit for up to 20 outpatient visits per calendar year. Also covered under separate PG&E Alcohol and Drug Care Program with referral by ValueOptions.

Eligible Dependents and Member Rights
See your PG&E Summary of Benefits Handbook for a complete description of eligibility, COBRA rights, Qualified Medical Child Support Order procedures and rights, ERISA rights and information, plan funding and plan continuation provisions.

Choice of Providers
Members must select a contracting Physician Group where the member wants to receive medical care. That Physician Group will provide or authorize all medical care. Family members may select different contracting Physician Groups. However, each person must select a contracting Physician Group within a 30-mile radius of his or her residence or work location. In addition to selecting a contracting Physician Group, each member must choose a Primary Care Physician from the Physician Group. The Primary Care Physician provides and coordinates medical care. Providers are neither employed nor exclusively contracted by the HMO.

Plan Telephone Number: 1-800-624-8822

Web Site: www.pacificare.com

- This benefit chart is a summary only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your PacifiCare Evidence of Coverage. The Evidence of Coverage is the binding document between PacifiCare HMO and its members.
- If you enroll in PacifiCare, you can request an Evidence of Coverage from PacifiCare, free of charge. It describes PacifiCare's benefit provisions, claims procedures, provider network information and other rules in detail. If you need additional information, including a list of participating network providers, you can contact PacifiCare directly. You may also contact the HR Service Center at 415-973-2363 (Co. extension 223-2363) or 1-800-788-2363, which will forward your request for additional information to PacifiCare.

Your Cost
Your cost is dependent on your retiree, bargaining unit or Flex employee status. Refer to your 2003 Enrollment Guide that you received in Fall 2002, call the HR Service Center or visit the Company's intranet site at wwwhr.

Important Note: The information contained in this summary is informational. No right shall accrue to you and/or your dependents because of any statement of error, or in omission from, this summary. Your health plan's Evidence of Coverage (EOC) is the binding document between the health plan and its members.

Health Net Seniority Plus HMO

This information along with your health plan's Evidence of Coverage represents an update to your *Summary of Benefits Handbook*.

Deductible Requirements
Not applicable

Inpatient Hospital – Room and Board, Anesthesia, Surgery, Other Services (incl. Ambulance)
No charge to members

Skilled Nursing Facility
No charge to members; limited to 100 days per benefit period.

Outpatient Hospital and Surgery
Members pay $5 per visit if surgery is in physician's office; no charge if in hospital

Emergency Room Care
Members pay $20 per visit; waived if admitted as inpatient

Doctor Visits
Members pay $5 per office visit; members pay $5 per home visit when medically necessary. Members pay $20 per urgent care visit.

Preventive Health Care including Routine Physicals
Members pay $5 per visit

Outpatient X-rays and Lab Tests
No charge to members

Pre-Admission Testing
No charge to members

Home Health Care and Hospice Care
No charge to members; coordinated with Medicare. Inpatient hospice covered under Medicare

Outpatient Physical Therapy
No charge to members

Outpatient Prescription Drugs
At retail pharmacy, members pay $5 copayment for up to a 30-day supply. For mail-order drugs, members pay $5 for up to a 90-day supply. Only formulary drugs.

Prosthetics and Durable Medical Equipment
No charge to members

Mental Health, Alcohol and Drug Care – Outpatient
Members pay $20 per visit; no visit limit. Outpatient alcohol/drug care also covered by PG&E's separate Alcohol and Drug Care Program with referral by ValueOptions.

Mental Health, Alcohol and Drug Care– Inpatient
No charge to members up to 190 days per lifetime. (Mental health and alcohol/drug days combined for limit.) Inpatient alcohol/drug care also covered by PG&E's separate Alcohol and Drug Care Program with referral by ValueOptions.

Eligible Dependents and Member Rights
See your PG&E Summary of Benefits Handbook for a complete description of eligibility, COBRA rights, Qualified Medical Child Support Order procedures and rights, ERISA rights and information, plan funding and plan continuation provisions.

Choice of Providers
Members must select a contracting Physician Group where the member wants to receive medical care. That Physician Group will provide or authorize all medical care. Family members may select different contracting Physician Groups. However, each person must select a contracting Physician Group close enough to his or her residence to allow reasonable access to medical care. In addition to selecting a contracting Physician Group, each member must choose a Primary Care Physician from the Physician Group. The Primary Care Physician provides and coordinates medical care. Providers are neither employed nor exclusively contracted by the HMO.

Plan Telephone Number: 1-800-275-4737

Web Site: www.healthnet.com

- This benefit chart is a summary only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your Health Net Seniority Plus Evidence of Coverage. The Evidence of Coverage is the binding document between Health Net Seniority Plus HMO and its members.
- If you enroll in Seniority Plus, you will receive an Evidence of Coverage, free of charge. It describes Seniority Plus' benefit provisions, claims procedures, provider network information and other rules in detail. If you need additional information, including a list of participating network providers, you can contact Seniority Plus directly. You may also contact the HR Service Center at 1-800-700-0057, which will forward your request for additional information to Seniority Plus.

Your Cost
Your cost is dependent on your retiree status. Refer to your 2003 Medical Care Enrollment Guide that you received in Fall 2002, or call the HR Service Center.

Important Note: The information contained in this summary is informational. No right shall accrue to you and/or your dependents because of any statement of error, or in omission from, this summary. Your health plan's Evidence of Coverage (EOC) is the binding document between the health plan and its members.

Kaiser Permanente Senior Advantage HMO (North and South)

This information along with your health plan's Evidence of Coverage represents an update to your *Summary of Benefits Handbook*.

Deductible Requirements
Not applicable

Inpatient Hospital – Room and Board, Anesthesia, Surgery, Other Services (incl. Ambulance)
No charge to members

Skilled Nursing Facility
No charge to members; 100 days per benefit period following 3-day hospital stay

Outpatient Hospital and Surgery
Members pay $5 per visit

Emergency Room Care
Members pay $20 per visit; waived if admitted as inpatient

Doctor Visits
Members pay $5 per office visit including urgent care visits at a Kaiser Permanente facility. Members pay $20 for urgent care visits at a non-Kaiser facility. No charge for home visits.

Preventive Health Care including Routine Physicals
Members pay $5 per visit

Outpatient X-rays and Lab Tests
No charge to members

Pre-Admission Testing
No charge to members

Home Health Care and Hospice Care
No charge to members; coordinated with Medicare. Inpatient hospice covered under Medicare

Outpatient Physical Therapy
Members pay $5 per visit for two-month period; another two-month period may be prescribed if potential exists for significant improvement.

Outpatient Prescription Drugs
Members pay $7 per fill for up to a 100-day supply when obtained at plan pharmacy or through plan's mail order; only formulary drugs.

Prosthetics and Durable Medical Equipment
No charge to members

Mental Health, Alcohol and Drug Care – Outpatient
Members pay $5 for individual visits or mental health group visit. Members pay $2 per alcohol and drug care group visit.

Mental Health – Inpatient
No charge to members up to 190 days per lifetime. No charge for 45 additional days per calendar year after 190-day limit is reached. No day limit for severe mental health diagnoses.

Alcohol and Drug Treatment – Inpatient
Detoxification only

Eligible Dependents and Member Rights
See your PG&E Summary of Benefits Handbook for a complete description of eligibility, COBRA rights, Qualified Medical Child Support Order procedures and rights, ERISA rights and information, plan funding and plan continuation provisions.

Choice of Providers
Members must use Kaiser Permanente facilities and physicians, except for emergencies or as noted in the Evidence of Coverage. A Kaiser Permanente physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat a member's medical condition. The services and supplies must be provided, prescribed, authorized or directed by a Kaiser Permanente physician. Members may choose a primary care physician.

Plan Telephone Number: 1-800-443-0815

Web Site: www.kaiserpermanente.org/california

- This benefit chart is a summary only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your Kaiser Permanente Senior Advantage Evidence of Coverage. The Evidence of Coverage is the binding document between Kaiser Permanente Senior Advantage HMO and its members.
- If you enroll in Senior Advantage, you will receive an Evidence of Coverage, free of charge. It describes Senior Advantage's benefit provisions, claims procedures, provider network information and other rules in detail. If you need additional information, including a list of participating network providers, you can contact Senior Advantage directly. You may also contact the HR Service Center at 1-800-700-0057, which will forward your request for additional information to Kaiser Permanente Senior Advantage.

Your Cost
Your cost is dependent on your retiree status. Refer to your 2003 Medical Care Enrollment Guide that you received in Fall 2002, or call the HR Service Center.

Important Note: The information contained in this summary is informational. No right shall accrue to you and/or your dependents because of any statement of error, or in omission from, this summary. Your health plan's Evidence of Coverage (EOC) is the binding document between the health plan and its members.

PacifiCare Secure Horizons HMO

This information along with your health plan's Evidence of Coverage represents an update to your Summary of Benefits Handbook.

Deductible Requirements
Not applicable

Inpatient Hospital – Room and Board, Anesthesia, Surgery, Other Services (incl. Ambulance)
No charge to members

Skilled Nursing Facility
No charge to members; 100 days per calendar year following 3-day hospital stay

Outpatient Hospital and Surgery
Members pay $5 per visit if surgery is in physician's office; no charge if in hospital

Emergency Room Care
Members pay $20 per visit; waived if admitted as inpatient

Doctor Visits
Members pay $5 per office visit; members pay $5 per home visit when medically necessary. Members pay $20 per urgent care visit.

Preventive Health Care including Routine Physicals
Members pay $5 per visit

Outpatient X-rays and Lab Tests
No charge to members

Pre-Admission Testing
No charge to members

Home Health Care and Hospice Care
No charge to members if prescribed by a Secure Horizons contracted provider and coordinated with Medicare. Secure Horizons will advise member about availability of inpatient hospice services.

Outpatient Physical Therapy
No charge to members

Outpatient Prescription Drugs
At retail pharmacy, members pay $5 copayment for up to a 30-day supply. For mail-order drugs, members pay $5 for up to a 90-day supply. Only formulary drugs.

Prosthetics and Durable Medical Equipment
No charge to members

Mental Health and Alcohol and Drug Care – Outpatient
Members pay $10 per visit; no visit limit. Outpatient alcohol/drug care also covered by PG&E's separate Alcohol and Drug Care Program with referral by ValueOptions.

Mental Health, Alcohol and Drug Care – Inpatient
No charge to members up to 190 days per lifetime. (Mental health and alcohol/drug days combined for limit.) Inpatient alcohol/drug care also covered by PG&E's separate Alcohol and Drug Care Program with referral by ValueOptions.

Eligible Dependents and Member Rights
See your PG&E Summary of Benefits Handbook for a complete description of eligibility, COBRA rights, Qualified Medical Child Support Order procedures and rights, ERISA rights and information, plan funding and plan continuation provisions.

Choice of Providers
Members must select a contracting Physician Group where the member wants to receive medical care. That Physician Group will provide or authorize all medical care. Family members may select different contracting Physician Groups. However, each person must select a contracting Physician Group within a 30-mile radius of his or her residence or work location. In addition to selecting a contracting Physician Group, each member must choose a Primary Care Physician from the Physician Group. The Primary Care Physician provides and coordinates medical care. Providers are neither employed nor exclusively contracted by the HMO.

Plan Telephone Number: 1-800-228-2144

Web Site: www.pacificare.com

- This benefit chart is a summary only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your PacifiCare Secure Horizons Evidence of Coverage. The Evidence of Coverage is the binding document between PacifiCare Secure Horizons HMO and its members.
- If you enroll in Secure Horizons, you will receive an Evidence of Coverage, free of charge. It describes Secure Horizons' benefit provisions, claims procedures, provider network information and other rules in detail. If you need additional information, including a list of participating network providers, you can contact Secure Horizons directly. You may also contact the HR Service Center at 1-800-700-0057, which will forward your request for additional information to Secure Horizons.

Your Cost
Your cost is dependent on your retiree status. Refer to your 2003 Medical Care Enrollment Guide that you received in Fall 2002, or call the HR Service Center.

Important Note: The information contained in this summary is informational. No right shall accrue to you and/or your dependents because of any statement of error, or in omission from, this summary. Your health plan's Evidence of Coverage (EOC) is the binding document between the health plan and its members.