WHAT'S INSIDE?

Benefits Open Enrollment

2013
Legal Supplement

PG&E®

GRANDFATHERED HEALTH PLAN NOTICE

The Pacific Gas and Electric Company Health Care Plan for Active Employees is a "grandfathered health plan" under the Patient Protection and Affordable Care Act of 2010 (PPACA). The Health Account Plan option for Management and A&T Employees is the only option under the Plan that is not grandfathered.

As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that already was in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the PPACA that apply to other plans—for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the PPACA, such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to lose grandfathered status can be directed to the plan administrator: Pacific Gas and Electric Company Plan Administrator, Benefits Department, 1850 Gateway Boulevard, 7th Floor, Concord, CA 94520. Or, you may contact the Employee Benefits Security Administration, U.S. Department of Labor at **866-444-3272** or www.dol.gov/ebsa/healthreform. This website has a table summarizing the protections that apply to grandfathered health plans.

What's Inside?

Medicare Coverage

If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, please see page 23 for information about your prescription drug coverage and Medicare.

Introduction

This *2013 Legal Supplement* 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 Flexible Spending Account Plan (formerly called the Health Care Reimbursement Account)
- The Pacific Gas and Electric Company Dependent Care Flexible Spending Account Plan (formerly called the Dependent Care Reimbursement Account)
- Pacific Gas and Electric Company Health and Welfare Benefits Pre-Tax Plan

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 Health Care Flexible Spending Account Plan.

Participating Employers

The Employers participating in the 2013 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 Management and Administrative & Technical employee 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 *Summary of Benefits Handbook for Retirees and Surviving Dependents.*

RE-ENROLLING AFTER CANCELLING MEDICAL COVERAGE

Retirees who cancel medical plan coverage on or after January 1, 2003, may re-enroll in a PG&E-sponsored retiree medical plan during any subsequent Open Enrollment period. To initiate re-enrollment for 2014, you must call the HR Service Center to request an Open Enrollment packet **no later than September 1, 2013**. 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 enroll for coverage in 2013 and you do not notify the HR Service Center by September 1, 2013, that you want coverage for 2014, you will not be able to re-enroll for 2014—even if you cancelled PG&E-sponsored coverage because you had other medical coverage and you subsequently lost that other coverage.

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

Note: 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 CONTRIBUTIONS

If you are a retiree and do not pay your medical plan contributions or any required restitution for covering ineligible dependents, your coverage will be permanently 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 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 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 cancel medical plan coverage will not be able to enroll in a PG&E-sponsored medical plan at any time in the future.

COST OF COVERAGE

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

If you die as an active employee from injuries sustained in the course of your employment while performing your job and you are covered under a PG&E-sponsored medical plan, subject to the eligibility rules discussed in this section, your enrolled surviving dependents will be eligible for PG&E-paid coverage for up to six months. After six months, the surviving dependents may continue their PG&E-sponsored medical coverage by paying the full cost of coverage.

In addition, if at the time of your death you are covered under a PG&E-sponsored dental plan, vision plan or the Employee Assistance Program (EAP), your enrolled surviving dependents will be eligible to continue their coverage through PG&E-paid COBRA for up to six months. After six months and until expiration of COBRA coverage, the surviving dependents may continue their PG&E-sponsored dental, vision and EAP coverage by paying the full COBRA rate.

For more information about COBRA, see page 16.

NON-PAYMENT OF SURVIVING DEPENDENT MEDICAL CONTRIBUTIONS

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

Eligible Dependents

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.

Eligible dependents include:

- Your legally married spouse, legally state-recognized common-law spouse, or registered domestic partner.
- Your children who are under age 26, including stepchildren, 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), who are not eligible for coverage under an employer-sponsored health plan. Eligibility for coverage under another parent's group health plan does not count for this purpose. If you're enrolled in the Health Account Plan (HAP), you can enroll your adult child in the HAP regardless of eligibility for other coverage from a different employer.
- The children of your registered domestic partner who are under age 26, including legally adopted children (for employees and retirees only) who are not eligible for coverage under an employer-sponsored health plan. (Note that a child for whom your registered domestic partner is the legal guardian is not an eligible dependent.) Eligibility for coverage under another parent does not count for this purpose. If you're enrolled in the Health Account Plan (HAP), you can enroll your adult child in the HAP regardless of eligibility for other coverage from a different employer.
- Your disabled children or those of your spouse/registered domestic partner who are age 26 or older; who are certified as disabled by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.); and who have been approved by a PG&E-sponsored medical plan provider for continued coverage before they reached age 26. 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 both are Management and Administrative & Technical employees; both are Union-Represented employees; or both are 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.

Federal law requires Social Security numbers (SSNs) for many eligible dependents. If a dependent SSN is listed as "Missing," on your Benefits Enrollment Worksheet, please contact the HR Service Center at **415-973-4357** or **800-788-2363** (retirees call **800-700-0057**), and provide the SSN in order to continue coverage for that dependent.

MINI-MED PLANS

If your child under age 26 only has access to a "mini-med" plan offered by another employer, PG&E will allow you to enroll your eligible child as a dependent in your PG&E-sponsored health care coverage. Mini-med plans are medical plans that provide extremely limited coverage and have been granted an official waiver from the annual benefit caps on essential health benefits by the U.S. Department of Health and Human Services.

Your adult child should receive an annual notice of this waiver from his or her employer or health insurance issuer. You should keep a copy with your records, as you may be asked to submit this notice to PG&E to validate your child's eligibility for PG&E-sponsored coverage.

Tax Implications of Coverage for Your Adult Children

For federal and state income tax purposes in all states, the value of health care coverage provided to your adult child is excluded from your income. In other words, it is not taxable.

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 children of a registered domestic partner or same-sex spouse may be 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).

CALIFORNIA TAXES

For California income tax purposes, the value of the health care benefits provided to 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

If you're an active employee, you can find more information about domestic partner registration and benefits for registered domestic partners and same-sex spouses in *Your Guide to Domestic Partner Benefits at Pacific Gas and Electric Company* on PG&E's HR intranet site.

If you're an employee on Long-Term Disability or a retiree, please call the HR Service Center for a copy of the guide.

TAX INFORMATION FOR DOMESTIC PARTNERS AND SAME-SEX SPOUSES

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, 2012, will not be processed for 2013.

IMPORTANT:

Did you know that you may be eligible for state health care coverage premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)?

California is not participating in CHIP for 2013.

Please see the notice starting on page 20.

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 coverage costs will be adjusted to reflect the coverage of the child, if applicable. If you are enrolled in a health plan with a defined service area and your child does not live within your plan's service area, you will be switched to the Anthem Blue Cross administered medical plan, as applicable for your family's ZIP code and employment status, and you will be responsible for paying the required contributions associated with that plan.

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 former domestic partner or an unregistered domestic partner (must be formally registered with valid registry)
- Parents, stepparents, parents-in-law, grandparents and stepgrandparents
- Former stepchildren or the stepchildren 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 25 who are eligible for coverage under an employer-sponsored health plan, such as through their own employer's plan or through their spouse or domestic partner's employer's plan (eligibility for coverage under another parent's group health plan does not count for this purpose). Unmarried children who are full-time students remain eligible for coverage whether or not they are offered other employer-sponsored coverage. If you're enrolled in the Health Account Plan (HAP), you can enroll your adult child in the HAP regardless of eligibility for other coverage from a different employer.

- Children age 26 and older, unless they have been approved for continued coverage under the Disabled Dependent provision for PG&E-sponsored medical plans
- Children who have entered the military (regardless of age or disability status)
- A spouse, common-law spouse, or domestic partner of your eligible child
- 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 Management or A&T employee of a Participating Employer, or a family member who is a Management or A&T employee if you are a Union-Represented employee of a Participating Employer

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 cost of coverage.

If you are a retiree or surviving dependent and you do not pay your required restitution for covering an ineligible dependent, your coverage will be permanently 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 back cover.

When You Can Enroll

You have an opportunity to choose which PG&E benefits you'd like to participate in:

- **During the annual Open Enrollment period** (two weeks each year in the fall). Changes you make during Open Enrollment become effective January 1 of the following year.
- **When you experience an eligible change-in-status event**, such as marriage or the birth of a child. You must report eligible change-in-status events to the HR Service Center within 31 days of the event (180 days for the birth or adoption of a child) in order to make any allowable changes to your benefits. Midyear change-in-status events do not apply to retirees or surviving dependents who are not already enrolled in a PG&E-sponsored medical plan at the time of the status change. See page 12 for more information.
- **If you're an employee who is eligible to participate in PG&E benefits, you can enroll when you're first hired by a Participating Employer.** You must complete the benefits enrollment form included in your benefits enrollment kit and return it to the HR Service Center within 31 calendar days of your hire date in order to have coverage. Elections you make generally become effective the first of the month following receipt of your elections. See page 9 for details about what happens if you don't enroll in coverage within 31 days.

During Open Enrollment

Depending on your employment status, you have these options for enrolling or making changes to your coverage during Open Enrollment:

YOUR EMPLOYMENT STATUS	COMPANY INTRANET: PG&E@Work For Me Accessible from home via Citrix or VPN	INTERNET: https://myportal.pge.com Must use Internet Explorer version 8.0 or lower	PHONE: HR Service Center
• Active Management and A&T employees who are not chiefs (supervisors) or delegates • Active ESC-represented employees	✓	✓	
• Active IBEW- or SEIU-represented employees	✓	✓	✓ 415-973-4357 800-788-2363
• Active Management and A&T employees who are chiefs (supervisors) or delegates*	✓		
• Employees on Long-Term Disability, leave of absence or Workers' Compensation	✓	✓	✓ 415-973-4357 800-788-2363 See Guidelines for Employees on Leave of Absence on page 10 for details
• Retirees and surviving dependents		✓	✓ 415-972-7077 800-700-0057

*SAP role assignments require chiefs and delegates to enroll through Citrix or VPN.

If You Don't Enroll

For Employees

If you're currently enrolled in PG&E-sponsored health care coverage and you don't enroll during Open Enrollment:

- **You'll continue to receive the same level of medical, dental and vision coverage** (single or family) that you and your covered dependents have in 2012, as listed on the 2013 Enrollment Worksheet included in your Open Enrollment packet. You'll be responsible for making any required contributions, as listed on your 2013 Enrollment Worksheet.
  - **If your current medical plan will no longer be available in 2013,** your Enrollment Worksheet will indicate with an asterisk (*) the alternative medical plan you'll automatically receive for 2013 if you don't enroll. You'll be responsible for making any required contributions, as listed on your 2013 Enrollment Worksheet.
- **If you're participating in the Health Care Flexible Spending Account (FSA) or Dependent Care FSA in 2012** (formerly referred to, respectively, as the Health Care Reimbursement Account and Dependent Care Reimbursement Account), enrollment for 2013 is not automatic. If you want to participate in an FSA for 2013, you'll need to enroll.
- **If the Health Savings Account Medical Plan (HSA Medical Plan) is still available for you in 2013 and if you're contributing to the HSA in 2012,** your contribution amounts will remain the same for 2013, provided you remain enrolled in the HSA Medical Plan for 2013.

If you're not currently enrolled in PG&E-sponsored health care coverage and you don't enroll, you'll have no coverage for 2013.

If you're currently enrolled and you want to waive coverage for 2013, you need to elect that option during Open Enrollment.

For Retirees

If you're currently enrolled in a PG&E-sponsored retiree medical plan and you make no changes to your medical plan or covered dependents, you'll continue to receive your current 2012 medical coverage for yourself and your eligible, covered dependents, as listed on the enclosed 2013 Enrollment Worksheet.

If your current medical plan will no longer be available in 2013, your Enrollment Worksheet will indicate with an asterisk (*) the alternative medical plan you'll automatically receive for 2013 if you don't enroll. You'll be responsible for making any required contributions, as listed on your 2013 Enrollment Worksheet.

You're responsible for making any required monthly contributions for you and your dependents' medical plan coverage as listed on your 2013 Enrollment Worksheet. If you're currently not enrolled in a PG&E-sponsored retiree medical plan and you don't enroll, you will have no coverage for 2013.

Guidelines for Employees on Leave of Absence

If you're on a leave of absence, special enrollment guidelines apply to you.

Your Contributions for Health Care Coverage: The amounts you pay for coverage vary depending on your leave of absence and whether you were a Union-Represented employee or Management or A&T employee prior to your leave. For Union-Represented employees, the rates also vary based on whether you were a full-time or part-time employee prior to your leave.

- **If you have been on medical leave for fewer than 12 months or you're on an emergency military leave:**
  - **Full-time Union-Represented employees and full-time or part-time Management and A&T employees** will pay the same amount for health care coverage as an employee who works full-time will pay.
  - **Part-time Union-Represented employees** will pay an amount that reflects their part-time status before going on leave.
- **If you're a Management or A&T employee on a personal leave, educational leave or regular military leave,** you'll pay:
  - **First three months:** The same amount for medical and dental coverage as an employee who works full-time will pay.
  - **Subsequent months:** 100% of the cost of medical coverage.
- **If you're a Union-Represented employee on a personal leave, educational leave or regular military leave,** you'll pay:
  - **First three months:** The same amount for coverage as an employee on medical leave will pay, which varies depending on your full-time or part-time status before the start of your leave.
  - **Subsequent months:** 100% of the cost of coverage.

The rates shown on your personalized Enrollment Worksheet reflect your portion of the medical plan contributions for each available medical plan option. The rate will be deducted from your pay when you return to work or you'll be billed on a monthly basis, depending on the election you make when you begin your leave.

- **If you're on a medical leave** that will continue into 2013 and you're being billed for your coverage contributions, you'll be billed at the new rate, as shown on your Enrollment Worksheet, beginning January 1, 2013.
- **If you're on a personal leave (including child care leave)** and paying the full cost of coverage, or if you'll start the fourth month of your leave in January 2013, you'll be responsible for paying the rate shown on your Enrollment Worksheet.
- **If you elect to defer payment of your coverage contributions while on leave,** the 2013 amounts listed on your Enrollment Worksheet will begin accruing effective January 1, 2013. All deferred coverage contributions will be deducted from your pay when you return to work, in addition to your regular coverage contributions.

In all cases, if your current medical plan will no longer be available in 2013, your Enrollment Worksheet will indicate with an asterisk (*) the alternative medical plan you'll automatically receive for 2013 if you don't enroll. You'll be responsible for making any required contributions, as listed on your 2013 Enrollment Worksheet.

Dependent Care FSA: You're not eligible to participate in the Dependent Care FSA while on leave, but you'll have an opportunity to participate when you return to work.

Health Care FSA: If you're on an unpaid leave of absence, you may elect to contribute to the Health Care FSA for 2013 on an after-tax basis. If you elect this option, you'll receive a *Health Care FSA Election While on a Leave of Absence* form soon after you enroll. You must complete this form and return it to the HR Service Center within 15 days of receipt. Send it to the address on the form.

Health Savings Account (HSA): If you're enrolled in the HSA Medical Plan and you were contributing to the HSA before your unpaid leave began, your payroll contributions will stop. However, if the HSA Medical Plan is still available for you in 2013, you may continue contributing to your HSA on an after-tax basis as long as you remain enrolled in the HSA Medical Plan. To contribute, you'll need to send your contributions directly to the HSA administrator, which is Aon Hewitt for 2013. If you want to contribute directly to your HSA, you'll need to use after-tax dollars and later deduct your contributions from your federal income taxes. It is your responsibility to ensure that your total contributions for the year do not exceed the total annual federal limit. When you return to work, please call the HR Service Center if you'd like to restart payroll contributions.

Vacation Buy Policy: Management and A&T employees are not eligible for the Vacation Buy policy while on leave of absence.

Contact the HR Service Center if you have questions. Representatives are available Monday through Friday, 7:30 a.m. to 5 p.m. Pacific Time.

How Your Leave Status May Affect Your Coverage

If you return to work before the end of 2012:

The 2012 health care elections you made before your leave, including your Dependent Care FSA (but not including your Health Care FSA), if applicable, will automatically resume the first of the month following your return to work. Dependent Care FSA contributions will be taken at the same monthly rate as before your leave, unless you made changes due to an eligible change-in-status event. Dependent Care FSA expenses for services incurred during your unpaid leave will not be eligible for reimbursement.

If you want to reinstate your participation in the Health Care FSA because you did not continue the Health Care FSA during your leave, you must call the HR Service Center within 31 days of your return to work. You may either elect to reinstate your original monthly contribution amount or your original annual contribution amount. If you elect to reinstate your original annual contribution amount, your contributions for the remaining plan year will be increased on a prorated basis to account for your missed contributions while you were on leave. Health Care FSA expenses for services incurred during your unpaid leave will not be eligible for reimbursement. If you do not call within 31 days, you will not be enrolled in this account for the remainder of the year.

Any elections you make during the annual Open Enrollment period will become effective January 1, 2013. If you make no changes during Open Enrollment, you and your eligible enrolled dependents will continue to be enrolled in the plans you were enrolled in prior to your leave. However, you will not be able to participate in the FSAs in 2013 unless you have an eligible change-in-status event. In addition, Management and A&T employees will not be able to purchase any Vacation Buy Days in 2013.

If you return to work in 2013:

If you make no changes during Open Enrollment, effective January 1, 2013, you and your eligible enrolled dependents will continue to have the same level of medical coverage you have in 2012. If your 2012 medical plan is no longer available for 2013, you'll automatically receive the alternative medical plan listed on your 2013 Enrollment Worksheet. You'll be responsible for making any required contributions as listed on your 2013 Enrollment Worksheet.

When you return to work, you'll receive another enrollment packet and you'll be able to change your benefit and coverage elections for the remainder of 2013. Any changes you elect will take effect the first of the month following receipt of your elections, provided the HR Service Center receives your elections within 31 days of the date on which you return to work. In addition to changing health care coverage, you'll be able to:

- Add eligible dependents acquired during your leave
- Enroll in the Health Care FSA if you didn't enroll in this account during Open Enrollment
- Enroll in the Dependent Care FSA if your needs for dependent care changed because you returned to work

In addition, Management and A&T employees will be able to purchase up to five Vacation Buy Days.

If you make no elections for yourself and your eligible dependents within 31 days of your return to work, you'll have the same coverage you elected during Open Enrollment or the same level of coverage you had while on leave, if you made no changes during Open Enrollment. You won't be able to participate in the Health Care FSA or Dependent Care FSA in 2013. In addition, Management and A&T employees won't be able to purchase any Vacation Buy Days in 2013.

Changing Coverage During the Year (Change-in-Status Events)

If you experience an eligible change-in-status event such as marriage or divorce, you have 31 days to make any allowable changes to your benefits (180 days for the birth or adoption of a child). Otherwise, you may not be able to make changes until the next Open Enrollment period.

If you're a retiree or surviving dependent, you must be currently enrolled in a PG&E-sponsored medical plan to request a benefit change due to a change-in-status event.

To request an allowable benefit change due to a change-in-status event, you must call the HR Service Center within 31 days (180 days for the birth or adoption of a child) of the date of the event. Representatives are available Monday through Friday, 7:30 a.m. to 5 p.m. Pacific Time.

What's a Change-in-Status Event?

After you have 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 law 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 FSA, cannot be altered due to a change in status relating to a domestic partnership or same-sex spouse. Eligible change-in-status events are listed below.

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

See "HIPAA Special Enrollment Rights for Employees" on page 15 for certain other permissible midyear coverage changes.

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 child
- Your child reaching the plan's age limit or entering the military
- You or your dependent becoming eligible for Medicare or Medicaid
- A change of caregivers or a change in the cost for the services of a caregiver who is not a relative (for Dependent Care FSA Plan purposes only)
- A move out of your medical plan'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 also is allowed for retirees, but only if they are already enrolled in a PG&E-sponsored health plan)
- The retirement of your PG&E active employee spouse or registered domestic partner if you are covered as his or her dependent
- 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 also is 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*.

IMPORTANT:

If you are a retiree who cancelled medical plan coverage on or after January 1, 2003, you may re-enroll in a PG&E-sponsored retiree medical plan only during subsequent Open Enrollment periods. You may not enroll at any other time, even if you have what would otherwise be considered a midyear change-in-status event, unless you currently are a covered dependent of an active employee who retires and is enrolled in a PG&E-sponsored health care plan. See "Re-Enrolling after Cancelling Medical Coverage" on page 2.

Federal law allows coverage changes due to change-in-status events relating to domestic partners or same-sex spouses only 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 (180 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 (180 days for births and adoptions), you will not be able to make any changes until the next Open Enrollment period.

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.

IF YOUR MEDICAL PROVIDER WITHDRAWS FROM YOUR NETWORK

If any of your primary care physicians, specialists, medical groups, Independent Practice Associations (IPAs), hospitals or other providers withdraw from your medical plan during 2013, you will not be able to change medical plans.

Instead, you'll need to obtain services from a participating provider within your plan's network for the remainder of the year. The withdrawal of a provider from your plan is not an eligible change-in-status event.

MOVE OUT OF MEDICAL PLAN SERVICE AREA

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

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 dependents 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 180 days** of your child's birth or adoption to enroll the child in your health plan. If you don't call within 180 days and make any required retroactive coverage contributions, any health care expenses incurred by your child will not be covered and your child's coverage will be cancelled.

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.

Loss of Dependent Eligibility

You must drop ineligible dependents from coverage under PG&E-sponsored health plans within 31 days of a dependent's loss of eligibility. Employees of PG&E and other Participating Employers, and retirees who cover ineligible dependents will be required to make restitution to the company for the associated costs of providing health care coverage, up to two full years' of the cost of coverage.

Your adult children will remain eligible for PG&E-sponsored medical plan coverage until the end of the month in which they reach age 26 or until the end of the month in which they become eligible for other coverage from a different employer—whichever occurs first. Please note that if you are enrolled in the HAP, your adult children will remain eligible for PG&E-sponsored medical plan coverage until the end of the month in which they reach age 26 regardless of the availability of other coverage from a different employer. At that time, they can enroll in extended coverage through COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). In accordance with federal law, they'll be required to pay 102% of the cost of COBRA coverage. For more information about COBRA, see page 16.

Disabled Dependent Certification

If you have eligible dependents who are under age 26, disabled and currently enrolled in a PG&E-sponsored medical plan, you must contact your medical plan directly to request certification of ongoing eligibility due to a disability before your disabled dependent otherwise loses eligibility when he or she reaches age 26. If you do not complete the certification by a PG&E-sponsored medical plan on time, your disabled dependent no longer can continue to be enrolled in the plan, effective the first of the month following the month in which he or she reaches age 26. You also may be required to periodically attest to ongoing eligibility based on disability, after the initial certification.

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 180 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.

WHAT YOU NEED TO DO TO ACTIVATE COBRA

If you are an employee and you 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 you die, your dependent should contact the HR Service Center.

You need to request COBRA enrollment materials if:

- You divorce
- You legally separate
- You dissolve a registered domestic partnership
- Your child no longer qualifies as an eligible dependent under the plans

You must call the HR Service Center **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.

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.

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 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 back cover.

When Your COBRA Coverage Ends

COVERAGE UNDER BLUE SHIELD, HEALTH NET AND KAISER PERMANENTE HMO* PLANS

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.

*** For 2013, the Kaiser Permanente Senior Advantage HMO applies only to Medicare-eligible retirees and surviving dependents, and to Medicare-eligible employees on Long-Term Disability and their enrolled dependents.**

COVERAGE UNDER ANTHEM BLUE CROSS ADMINISTERED PLANS

If you're an Anthem Blue Cross member and your COBRA coverage is ending, you may contact your health plan 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.

Important Legal Notices

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 Flexible Spending Account Plan ("The Health Care Plans").

The HIPAA Notice is posted in the Tool Kit on the HR intranet site under Human Resources > Human Resources Forms, 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.

California is not participating in CHIP for 2013.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but who also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed in the following table, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are ***not*** currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office, dial **877-KIDS NOW** or visit **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at **www.askebsa.dol.gov** or by calling toll-free **866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2012. You should contact your own state for more information on eligibility.

ALABAMA—Medicaid
Website: http://www.medicaid.alabama.gov
Phone: **855-692-5447**

ALASKA—Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): **888-318-8890**
Phone (Anchorage): **907-269-6529**

ARIZONA—CHIP
Website: http://www.azahcccs.gov/applicants
Phone (Outside of Maricopa County): **877-764-5437**
Phone (Maricopa County): **602-417-5437**

COLORADO—Medicaid
Website: http://www.colorado.gov/
Phone (In state): **800-866-3513**
Phone (Out of state): **800-221-3943**

FLORIDA—Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: **877-357-3268**

GEORGIA—Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: **800-869-1150**

IDAHO—Medicaid and CHIP
Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: **800-926-2588**
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: **800-926-2588**

INDIANA—Medicaid
Website: http://www.in.gov/fssa
Phone: **800-889-9949**

IOWA—Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: **888-346-9562**

KANSAS—Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: **800-792-4884**

KENTUCKY—Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: **800-635-2570**

LOUISIANA—Medicaid
Website: http://www.lahipp.dhh.louisiana.gov
Phone: **888-695-2447**

MAINE—Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: **800-977-6740**
TTY: **800-977-6741**

MASSACHUSETTS—Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: **800-462-1120**

MINNESOTA—Medicaid
Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: **800-657-3629**

MISSOURI—Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: **573-751-2005**

MONTANA—Medicaid
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: **800-694-3084**

NEBRASKA—Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: **800-383-4278**

NEVADA—Medicaid
Website: http://dwss.nv.gov/
Phone: **800-992-0900**

NEW HAMPSHIRE—Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: **603-271-5218**

NEW JERSEY—Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: **800-356-1561**
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: **800-701-0710**

NEW YORK—Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: **800-541-2831**

NORTH CAROLINA—Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: **919-855-4100**

NORTH DAKOTA—Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: **800-755-2604**

OKLAHOMA—Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: **888-365-3742**

OREGON—Medicaid and CHIP
Websites: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: **877-314-5678**

PENNSYLVANIA—Medicaid
Website: http://www.dpw.state.pa.us/hipp
Phone: **800-692-7462**

RHODE ISLAND—Medicaid
Website: www.ohhs.ri.gov
Phone: **401-462-5300**

SOUTH CAROLINA—Medicaid
Website: http://www.scdhhs.gov
Phone: **888-549-0820**

SOUTH DAKOTA—Medicaid
Website: http://dss.sd.gov
Phone: **888-828-0059**

TEXAS—Medicaid
Website: https://www.gethipptexas.com/
Phone: **800-440-0493**

UTAH—Medicaid and CHIP
Website: http://health.utah.gov/upp
Phone: **866-435-7414**

VERMONT—Medicaid
Website: http://www.greenmountaincare.org/
Phone: **800-250-8427**

VIRGINIA—Medicaid and CHIP
Medicaid Website:
http://www.dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: **800-432-5924**
CHIP Website: http://www.famis.org/
CHIP Phone: **866-873-2647**

WASHINGTON—Medicaid
Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: **800-562-3022 ext. 15473**

WEST VIRGINIA—Medicaid
Website: http://www.dhhr.wv.gov/bms/
Phone: **877-598-5820,** HMS Third-Party Liability

WISCONSIN—Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: **800-362-3002**

WYOMING—Medicaid
Website: http://health.wyo.gov/healthcarefin/equalitycare
Phone: **307-777-7531**

To see if any more states have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor Services
Employee Benefits Security Administration
www.dol.gov/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877-267-2323, Ext. 61565

PACIFIC GAS AND ELECTRIC COMPANY MEDICARE PART D CREDITABLE COVERAGE NOTICE

Medicare-Eligible Participants: Important Notice About Your Prescription Drug Coverage and Medicare

This is a legally required notice that PG&E must provide annually to all employees, retirees and surviving dependents eligible for PG&E-sponsored medical coverage. Please read this notice and keep it where you can find it. No other action is required.

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 join 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 may also 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 standard Medicare prescription drug coverage pays and therefore is considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you enroll in a Medicare drug plan?

You can enroll in a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

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

What will happen to your current medical coverage if you decide to enroll in 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 Medicare Part D benefit.

If you decide to enroll in a Medicare drug plan that is not sponsored by PG&E (in other words, a plan not offered by PG&E during the enrollment period), **your PG&E-sponsored medical and prescription drug benefits will be terminated.**

Can you re-enroll in a PG&E-sponsored medical plan at a later date?

Eligible retirees, employees on Long-Term Disability and dependents who enroll in a non-PG&E Medicare drug plan will not be able to re-enroll in a PG&E-sponsored medical plan until the next Open Enrollment. If you're an eligible retiree and you want to initiate re-enrollment, you must call the HR Service Center to request an Open Enrollment packet no later than September 1 to elect coverage effective the following January 1.

Surviving dependents who enroll in 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.

KEEP THIS CREDITABLE COVERAGE NOTICE

This is a legally required notice about your benefits. Please read this notice carefully and keep it where you can find it.

If you decide to enroll in a Medicare drug plan, you may be required to provide a copy of this notice when you enroll to show that you have maintained creditable coverage. If you have maintained creditable coverage, you will not be required to pay a higher premium (a penalty).

When will you pay a higher premium (penalty) to enroll in a Medicare drug plan?

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% 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% 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 join.

Where can you find more information about PG&E-sponsored coverage?

For more information about this notice or your current PG&E-sponsored prescription drug coverage, contact the HR Service Center. NOTE: You'll get this notice each year before the next period you can enroll in a Medicare drug plan. You'll also get this notice if PG&E sponsored prescription drug coverage changes. You may request a copy of this notice at any time.

Where can you find more information about your options for Medicare prescription drug coverage?

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 drug plans.

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit **www.socialsecurity.gov** or call **800-772-1213** (TTY **800-325-0778**).

October 2012
Pacific Gas and Electric Company

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

Remember, keep this creditable coverage notice.

You will need it if you decide to enroll in a Medicare drug plan and want to avoid paying a higher premium (a penalty) for lack of creditable coverage.

Your Authorization—Please Read

By participating in any of the benefit plans sponsored by Pacific Gas and Electric Company, you:

- Acknowledge that you are responsible for reading the 2013 enrollment material, including your Enrollment Worksheet, *Benefits 2013* brochure, the *2013 Legal Supplement* and your confirmation statement;
- Acknowledge that you have received the "Notice about Your Prescription Drug Coverage and Medicare" included in the *2013 Legal Supplement*;
- For retirees, surviving dependents and individuals on Long-Term Disability (LTD), you acknowledge that you understand your PG&E medical and prescription drug coverage will be cancelled if you enroll in a Medicare Part D Prescription Drug Plan or Medicare Advantage Plan outside of the PG&E enrollment process;
- Agree to provide Pacific Gas and Electric Company or any Participating Employers with Social Security numbers and Medicare Claim Numbers, if applicable, for you and your dependents, and authorize Pacific Gas and Electric Company and any Participating Employers to release Social Security numbers and Medicare Claim Numbers for you and your dependents to governmental agencies, third-party administrators and insurers, as required, for purposes of plan administration;
- Authorize the Participating Employer to deduct any required before-tax or after-tax contributions from your pay, pension check or LTD benefits, or to bill you for any contributions you owe if your pension check or LTD benefits are insufficient;
- Acknowledge that the Health Savings Account is not an ERISA benefit or plan and that you are fully responsible for all investment decisions relating to funds held in any such account;
- Acknowledge that unless you experience an eligible change-in-status event, you will not be able to change medical plans during 2013 (a change-in-status event does not occur if your desired physician, hospital, medical group or Independent Physician Association (IPA) does not participate in or terminates its relationship with your medical plan's network);
- For active employees, you acknowledge that any current Health Care FSA, Dependent Care FSA and Vacation Buy Day elections cannot automatically roll forward into 2013 and that you must actively re-enroll to make new Health Care FSA, Dependent Care FSA and Vacation Buy Day elections for 2013;
- Agree to reimburse the Participating Employer for the value of any Vacation Buy Days taken but not paid for, should you terminate employment or transfer to a Union-Represented position during 2013;
- Acknowledge that PG&E, the other Participating Employers and the health plan administrators and insurers do not provide medical services or make treatment decisions; all treatment decisions are between you and your physician regardless of the benefits covered under the plan;
- Agree to follow the appeal process for your plan for any disputed benefit claims; and
- Agree to call the HR Service Center to report any ineligible dependents within 31 days of a dependent's loss of eligibility.

PG&E HR SERVICE CENTER	
Active employees and employees on leave or Long-Term Disability Phone: **415-973-4357** or **800-788-2363** Email: hrbenefitsquestions@exchange.pge.com	**Retirees and surviving dependents** Phone: **415-972-7077** or **800-700-0057** Email: hrbenefitsquestions@exchange.pge.com

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

Summary of Material Modifications (October 2012)

The *Benefits 2013* brochure and the *2013 Legal Supplement* constitute a Summary of Material Modifications to the PG&E Health Care Plans.

The *Benefits 2013* brochure for Management and Administrative & Technical Employees; the *Benefits 2013* brochure for Employees Represented by the IBEW, ESC and SEIU; the *Benefits 2013* brochure for Employees on Long-Term Disability; the *Benefits 2013* brochure for Retirees and Surviving Dependents; and the *2013 Legal Supplement* (referred to collectively as your "enrollment materials") 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. Your 2013 enrollment materials 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 brochures designated as Summaries of Material Modifications, as well as the Evidence of Coverage booklets issued by the HMOs. 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 to PG&E in this booklet and in other open enrollment materials mean Pacific Gas and Electric Company. Pacific Gas and Electric Company, PG&E Corporation and their affiliates are referred to collectively as "Participating Employers."