January 2005 – Summary of Material Modifications
Supplement to the January 2003 Summary of Benefits Handbook

The purpose of this Summary of Material Modifications is to notify you of important changes to your health care benefit plans sponsored by the Pacific Gas and Electric Company. Please read the enclosed information carefully and keep it with your *January 2003 Summary of Benefits Handbook* and other important benefit information. These modifications are effective January 1, 2005, except the Health Information Privacy modifications which were effective on April 14, 2004, or will be effective on April 20, 2005, as noted in the Health Information Privacy and Data Security section below.

The information contained in this notice is intended as a summary only. Although detailed in nature, this notice has been designed to provide you with an overview of the various benefit programs, and thus, does not include the important legal definitions or limitations which are in the plan documents or HMO contracts governing your benefits. Therefore, this notice does not replace those legal documents and, in case of conflict, those legal documents govern your benefits.

PART A: The following sections contain updates to COBRA, Discretionary Authority, Health Information Privacy and Data Security and Subrogation are applicable to participants of The Pacific Gas and Electric Company Health Care Plan for Active Employees, The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents and The Pacific Gas and Electric Company Health Care Reimbursement Account Plan

COBRA (Consolidated Omnibus Budget Reconciliation Act) - The following is an update to the *COBRA and Conversion to an Individual Policy* section of your *January 2003 Summary of Benefits Handbook*:

COBRA: Maximum Coverage Periods
The maximum COBRA coverage periods are calculated from the loss of coverage date.

COBRA: When Coverage Ends
In addition to the reasons already provided in this section of your *January 2003 Summary of Benefits Handbook*, your COBRA coverage could also end before the standard time periods if you become covered by another group health plan or your coverage is terminated for cause, such as submitting fraudulent claims.

COBRA: How to Obtain COBRA Continuation Coverage
If you divorce, legally separate, dissolve a domestic partnership, or if your dependent child no longer qualifies as an eligible dependent under the plans, you must complete and provide the *COBRA Qualifying Event Notification Form* in order for you or your qualified beneficiaries to obtain continued coverage through COBRA. COBRA rights may be jeopardized if the form is not provided to the HR Service Center within 60 days of the latter of the qualifying event date or the loss of coverage date. The required form can be obtained on the Company's intranet site or through the HR Service Center. For assistance, contact the HR Service Center at company extension 223-2363, or by calling externally, 415-973-2363 or 1-800-788-2363.

In the event you die, terminate your employment or lose health care coverage because of a reduction in work hours, the HR Service Center will automatically provide you or your dependents with

information regarding COBRA coverage. The *COBRA Qualifying Event Notification Form* is not required.

COBRA: Extension of COBRA Coverage Due to Disability

You and your qualified beneficiaries may elect a special 11-month extension to continue COBRA coverage for a total of up to 29 months if:

- the initial COBRA qualifying event is the employee's termination of employment or reduction in hours;
- a qualified beneficiary is determined under the Social Security Act to have been disabled at any time during the first 60-days of COBRA coverage; and
- the qualified beneficiary provides the Social Security Administration's determination to Ceridian, the Company's COBRA administrator, before the end of the initial 18-month coverage period and within 60 days of the latter of:
    - the date of Social Security's disability determination;
    - the date of the qualifying event; or
    - the benefit termination date.

Discretionary Authority - The following is an update to the *ERISA Information* section of your *January 2003 Summary of Benefits Handbook:*

The Employee Benefit Committee (EBC) of PG&E Corporation and, with respect to appeals regarding claims decisions only, the Employee Benefit Administrative Committee (EBAC) of Pacific Gas and Electric Company are the Plan Administrators for the Pacific Gas and Electric Company Health Care Plan for Active Employees and for the Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents (together, the Health Plans or Plans). The Plan Administrators have the discretionary authority for administration of the Health Care Plans which includes maintaining records, rules, computations, interpretations and decisions that in their discretion may be necessary for administration of the Plans. The Plan Administrators also have the discretionary authority to interpret, construe, and define the terms of the Health Care Plans and may advise the Plans' claim administrators of such interpretations, constructions and definitions.

Health Information Privacy and Data Security - The following is an addition to your *January 2003 Summary of Benefits Handbook*:

The Pacific Gas and Electric Company and its health plan partners are committed to protecting the privacy and confidentiality of the health information for eligible participants (including eligible employees, retirees and surviving spouses, and their eligible dependents) that is created or received in the administration of The Pacific Gas and Electric Company Health Care Plan for Active Employees, The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, and The Pacific Gas and Electric Company Health Care Reimbursement Account Plan.

Federal legislation known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the underlying privacy and security regulations issued by the U.S. Department of Health and Human Services, provide additional protection for individually identifiable health information (referred to as "Protected Health Information"). The privacy regulations were effective

April 14, 2004 and the security regulations will be effective April 20, 2005. Protected Health Information includes health information in any form or medium including paper, oral communications and electronic media. For this purpose, electronic media will include health information stored on computer hard drives, any removable/transportable digital memory medium, such as a magnetic tape or disk, optical disk, or digital memory card, as well as the various methods in which health information is transmitted electronically.

The Health Care Plans will not use or disclose an eligible participant's Protected Health Information, except as necessary for purposes of treatment, payment or health care operations, or as otherwise permitted by applicable law. The Plans may also disclose an eligible participant's Protected Health Information to authorized Pacific Gas and Electric Company personnel (including personnel at affiliated companies whose employees participate in the Health Care Plans) for these and other administrative purposes. Neither the Pacific Gas and Electric Company nor its authorized personnel will, without the eligible participant's written authorization, use or disclose his or her Protected Health Information for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by the Pacific Gas and Electric Company.

Under HIPAA, eligible participants have certain important rights with respect to Protected Health Information, including the rights to inspect and copy information, receive an accounting of certain disclosures of health information, and, under certain circumstances, amend the information that is incorrect or incomplete. Eligible participants may also request a restriction on the Protected Health Information that the Plans use or disclosure about their treatments, payments or health care operations, or that the Plans communicate with them about health matters using alternative means or at alternative locations. Eligible participants also have the right to file a complaint with the Plans or with the U.S. Department of Health and Human Services if they believe that their health information rights under HIPAA have been violated.

The Plans maintain a "HIPAA Notice of Health Information Privacy Practices" ("HIPAA Notice") that provides a description of how Pacific Gas and Electric Company and the Plans may use or disclose Protected Health Information, as well as eligible participants' health information rights under HIPAA. The Plan has implemented administrative, physical and technical safeguards designed to protect the confidentiality, integrity and availability of any Protected Health Information that it transmits, receives or maintains in any form of electronic media.

To receive more information about the Plans' health information privacy practices or HIPAA rights, or if Eligible Employees and Eligible Dependents have any questions about the HIPAA Notice, they may contact the Pacific Gas and Electric Company Plan Administrator, Benefits Department, N2P, P. O. Box 770000, San Francisco, CA, 94177.

Subrogation and Refund of Overpayments - The following section replaces language in the *January 2003 Summary of Benefits Handbook* that addresses third party liability and subrogation for the self-funded benefit plans under the Health Plans, including the self-funded medical plans (claims administrator UnitedHealthcare), the self-funded dental plans (claims administrator Delta Dental of California), the self-funded prescription drug plans (claims administrator Medco Health Solutions), the Vision Plan (claims administrator Vision Service Plan) and the Mental Health, Alcohol and Drug Care Program (claims administrator Value Options):

Subrogation

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. The Health Plans shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of any services and Health Care Benefits the Plans provide to you, or will provide to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by the Plans, the Plans shall also have an independent right to be reimbursed by you for the reasonable value of any services and Health Care Benefits the Plans provide to you, or will provide to you, from any amount received by any person from any or all of the following listed below:

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide Health Care Benefits or payments to you, including Health Care Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties".

You agree as follows:

- That you will cooperate with the Plans and its claims administrators in a timely manner in protecting the Plans' legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - notifying the Plans' claim administrator as soon as you learn that a Third Party may be liable for causing your need for Health Care Benefits,
  - providing any relevant information requested by the Plans or its claims administrator,
  - signing and/or delivering such documents as the Plans or its claim administrator reasonably requests to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - appearing at legal proceedings such as depositions and in court; and
  - obtaining the consent of the Plans or its claims administrator before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of Health Care Benefits and/or the institution of legal action against you.
- That the Plans have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- That no court costs or attorneys' fees may be deducted from our recovery without express written consent from the Plans or claims administrator; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plans are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, the Plans may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for collection shall include, but not be limited to, any and all amounts earmarked as non-economic damage settlement or judgment.
- That Health Care Benefits paid by the Plans or its claim administrator may also be considered to be Health Care Benefits advanced.
- That you agree that if you receive any payment from any Third Party or an insurer as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds received from any Third Party that are due and owed to the Plans, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of Health Care Benefits or the institution of legal action against you.
- That you shall transfer title to the constructive trust to the Plans for all Health Care Benefits that have been paid or will be paid as a result of your injury or illness.
- That the Plans shall be entitled to recover reasonable attorney fees from you incurred in collecting from you any funds held by you that you recovered from any Third Party.
- That the Plans may offset from any future Health Care Benefits otherwise allowed the value of Health Care Benefits paid or advanced under this section to the extent not recovered by the Plans.
- That you will neither accept any settlement that does not fully compensate or reimburse the Plans without the written approval of the Plans or its claims administrator, nor will you do anything to prejudice the Plans' rights under this provision.
- That you will assign to the Plans all rights of recovery against Third Parties, to the extent of the reasonable value of services and Health Care Benefits the Plans provided, plus reasonable costs of collection.
- That the Plans' rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom you are seeking recovery, to be paid before any other of your claims are paid. The Plans' rights apply to full and partial settlements or judgments obtained on your behalf.
- That the Plans' rights will not be reduced due to your own negligence.
- That the Plans may, at their option, take necessary and appropriate action to preserve their rights under these subrogation provisions, including filing suit in your name, which does not obligate the Plans in any way to pay you part of any recovery the Plans might obtain.
- That the Plans shall not be obligated in any way to pursue this right independently or on your behalf.
- That if the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section also applies to the parents or guardian of the minor child.
- That in the case of a wrongful death, this section also applies to your estate, personal representative of your estate, and your heirs or legatees.

- That if the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Plan Participant, also called "member", this section will apply to any personal representative of the Plan participant.

Refund of Overpayments
If a Plan pays Health Care Benefits for expenses incurred on account of a Plan Participant, the Plan Participant, or any other person or organization that was paid, must make a refund to the Plan or its claim administrator if either of the following apply:

- All or some of the expenses were not paid by the Plan participant or did not legally have to be paid by the Plan participant.
- All or some of the payment the Plan made exceeded the allowable Health Care Benefits designated by the Plan.

The refund should equal the amount the Plan paid in excess of the amount the Plan should have paid. If the refund is due from another person or organization, the Plan Participant agrees to help the Plan get the refund when requested.

If the Plan Participant or any other person or organization that was paid on behalf of the Plan Participant does not promptly refund the full amount, the Plan may reduce the amount of any future Health Care Benefits for the Plan Participant that are payable under the Plans. The reductions will equal the amount of the required refund. The Plans may have other rights in addition to the right to reduce future Health Care Benefits.

PART B: The following sections on Dependent Care Reimbursement Accounts and Military Leaves of Absences are applicable to participants of The Pacific Gas and Electric Company Health Care Plan for Active Employees and to participants of The Pacific Gas and Electric Company Dependent Care Reimbursement Accounts

Dependent Care Reimbursement Accounts - The following is an update to the *Reimbursement Accounts* section of your *January 2003 Summary of Benefits Handbook*:

The Working Families Tax Relief Act of 2004 partially redefined eligibility for the Dependent Care Reimbursement Account effective January 1, 2005.

For children under age 13: Assuming that you and your spouse (if applicable) continue to meet the work or school requirement, as in the past, your daycare expenses for dependents under age 13 who live with you will continue to constitute "eligible expenses". If your dependent does not live with you for more than half the year, or is a child of a Domestic Partner, your daycare expenses for that child may not be eligible.

For dependents age 13 and over: In addition, in the past your daycare expenses for non-children dependents who resided with you would be considered "eligible" expenses. Now, these expenses will only be eligible if the total annual income of the dependent is less than $3,200.

Military Leaves of Absence - The following is an update to the *Time Off* section of your *January 2003 Summary of Benefits Handbook*:

In accordance with the Veterans Benefits Improvement Act of 2004, the company has extended the maximum period for health plan continuation coverage under Uniformed Service Employment and Reemployment Rights Act (USERRA) from 18 months to 24 months. This change applies to regular military leave of absence and elections for USERRA coverage that are made on or after December 10, 2004. Medical coverage will continue for the first 3 calendar months provided the employee pays any applicable premium contribution. Commencing the 4th calendar month, the employee must pay full premium to continue coverage up to a total of 24 months. Dental and vision coverage for full-time employees will continue up to 24 months. Dental and vision coverage will continue for union represented part-time employees provided the employee pays the applicable premium contribution.

PART C: For members of medical plans Administered by UnitedHealthcare (the Network Access Plan (NAP), the Comprehensive Access Plan (CAP), the Basic Plan, the Retiree Optional Plan (ROP) and the Medicare Supplemental Plan)

The following sections are applicable to participants of 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 in medical plans administered by UnitedHealthcare.

Skilled Nursing Pre-authorization Requirement

Please remember that if you are in a UnitedHealthcare-administered medical plan and you are being admitted into a skilled nursing facility, you should call UnitedHealthCare's Care Coordination at 1-877-842-4743, Option 2, prior to your admittance to the facility. If you do not, you may be assessed a penalty. The penalty for members of the Comprehensive Access Plan (CAP) and Network Access Plan (NAP) is $300. This penalty will apply to both Medicare and non-Medicare members.

New Health Care Advocate Program

UnitedHealthcare (UHC) is introducing a new program for Pacific Gas and Electric members – the Heath Care Advocate program. Specially trained registered nurses will be available to assist you in navigating the complexities of your needed health care. Health Care Advocate nurses can be your personal advocates to help you deal with the stresses of hospitalization or management of a chronic or complex medical condition.

If you're hospitalized for certain scheduled surgeries, the Health Care Advocate nurses will work with you prior to admission to ensure you understand your upcoming procedure and recovery process. While you are in the hospital, the Health Care Advocate nurses will work with your doctors and the hospital to help ensure that your treatment goes smoothly and your recovery needs are met. Finally, when you return home, you'll receive follow-up calls to check on your recovery process and determine whether you have ongoing health care needs.

If you have a chronic or complex condition, the Health Care Advocate nurses will work with you and your doctors to develop a comprehensive care strategy and monitor your care. You also may receive a

phone call from these nurses offering their assistance if your medical and pharmacy data indicate that you might benefit from the program. These nurses can also help coordinate assistance from UHC's Cancer Resource and Transplant Resource Services programs.

Using the Health Care Advocate program is confidential and free-of-charge. If you have a chronic condition or upcoming hospitalization and would like to talk with a registered nurse, just call UHC's member services number at 1-877-842-4743, Option 3.

UnitedHealth Allies Program - Discounted Health Products and Services

All members of a UnitedHealthcare-administered medical plan are automatically eligible for the new UnitedHealth Allies program. UnitedHealth Allies is a health care discount program that allows members to access pre-negotiated savings of 10% to 50% on many health care purchases. This can be very useful for seeing providers and obtaining products that may not be covered by your medical, dental or vision plans. Examples of UnitedHealth Allies discounts include:

Vision	• Laser Eye Surgery • Eyeglasses and contact lenses
Dental	• Cosmetic Dentistry • Exams and Fillings
Alternative Medicine	• Massage Therapy • Acupuncture • Chiropractic Care
Wellness	• Weight Management • Fitness • Nutrition • Smoking Cessation
Hearing	• Hearing Care and Devices
Long Term Care	• Nursing and Assisted Living Facilities • Home Health Care
Pharmacy	• Lifestyle Products • Prescription Drugs

When you want to use a UnitedHealth Allies provider, all you need to do is show him or her your new UnitedHealthcare medical card. Please remember that UnitedHealth Allies is a discount program and is intended to be used when your regular health plan does not cover a particular service.

You can learn about services and providers in your area by:

- Visiting the UnitedHealth Allies website at www.unitedhealthallies.com or by visiting www.myuhc.com and clicking on "Other Benefits"
- Calling UnitedHealthcare member services toll free at 1-877-842-4743.

Medco Prescription Drug Rebates

The company may receive prescription drug rebates on a quarterly basis from Medco as a result of prescription drug purchases. Any rebates received by the company are deposited and credited to the applicable benefit trusts and accounts which reduce plan costs and participant premium contributions.