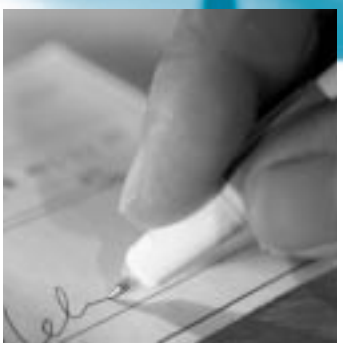
Pacific Gas and Electric Company®

2005

Bargaining Unit Health Care



Enrollment Guide

BARGAINING UNIT

Contents

SUMMARY OF MATERIAL MODIFICATIONS

October 2004

Take Charge of Your Health

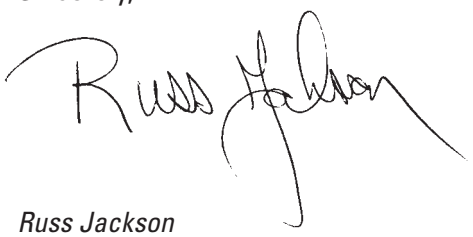
Descriptions of these plans do not include the important legal definitions or limitations that are in plan documents or HMO contracts governing your benefits. Therefore, this booklet does not replace those legal documents, and in case of conflict, those legal documents govern your benefits. The Plan Administrator of each plan has the discretionary authority to interpret the provisions of the plan. Since future conditions affecting the Company cannot be foreseen, the Company reserves the right to amend or terminate the plans at any time, subject to notice provisions required under applicable collective bargaining agreements. Although any change in a plan or the termination of a plan will not affect the benefits paid to plan members before the date the plan was changed or ended, such change may result in reduced levels of benefits or benefit coverage, or increased employee and/or retiree contributions, after the effective date of any such change.

A Message to PG&E Bargaining Unit Employees

On behalf of PG&E, I'm pleased to welcome you to the 2005 PG&E Bargaining Unit Health Care Open Enrollment. As you read through this Guide, you will find detailed information on new plan features, including a new HMO option for 2005. We also provide tips on how you can save money on your health care-related expenses — including using the Reimbursement Accounts to lower your taxable income — as well as how you can take a more active role in making your health care decisions and choosing the best plan for your situation. Just look for the "Important Tip" boxes found throughout the Guide.

You have important decisions to make and a variety of options from which to choose. We're here to help, so if you have any questions about your benefit plan options or how they work, please feel free to contact the HR Service Center at hrbenefitsquestions@pge.com or by calling company line 223-2363, 415-973-2363, or 800-788-2363.

Sincerely,



Russ Jackson
Senior Vice President, Human Resources
PG&E Corporation and Pacific Gas and Electric Company




Health Care Costs Continue to Rise

As you know, health care costs have risen dramatically in the past decade, far outpacing other costs and rates of inflation. Among the many reasons for this trend are huge prescription drug cost increases, broader access to new (and often more expensive) treatments, an aging population that uses benefits more frequently, and consolidations among hospital facilities. For example, experts predict that the cost of inpatient hospital stays and prescription drugs will increase by 12 percent and 15 percent, respectively, in 2005.

All this, combined with the fact that a record 45 million Americans now do not have health care coverage, paints a pretty daunting picture.

Fortunately, as a PG&E employee, you can choose from a variety of medical coverage options for the one that best suits your individual needs. Along with this coverage, PG&E also provides you with several tools that can help you reduce your medical costs and get the most out of your medical plan.

Take Charge of Your Health Care Decisions

One of the most important things you can do as a health care consumer is to get actively involved in making your own health care decisions. Because your situation and needs may change from year to year, you should carefully review the medical plan options available to you to make sure you are selecting the best option each year.

Here are some questions you might want to ask yourself when looking at your medical plan options:

What are my estimated out-of-pocket costs for 2005?

You should consider deductibles and copayments for:

- Primary care doctor, specialist, in-patient and out-patient hospital and emergency room visits for you and your covered dependents. **Remember, the HMO options have no deductibles or hospital copayments.**
- Prescription drugs.
- Chiropractic, acupuncture, physical therapy or other non-routine care (some plans have limited or no coverage for these services).
- X-rays, lab services and durable medical equipment. Unlike the UnitedHealthcare-administered plans, there typically are no charges for these expenses with the HMOs.
- Outpatient physical therapy visits.
- Mental health and substance abuse treatment.

Am I taking advantage of available tax breaks?

Health care is expensive — as is dependent care. Fortunately, PG&E provides you with the Health Care and Dependent Care Reimbursement Accounts, which can be used to decrease your taxable income by the amount you pay for many common expenses, which in turn lowers your taxes and increases your spendable income. Please read more about the Reimbursement Accounts on pages 19 – 21 in this Guide.

Are my routine medications covered by the plan I'm considering?

If not, you may have to pay full cost. Call the plan's member services number to find out. Also, remember that generic drugs are usually significantly less expensive than brand-name equivalents.

What is the monthly premium cost for the plan I'm considering?

HMO premiums are generally less expensive than those for the plans administered by UnitedHealthcare. So, if your doctors participate in an HMO, it may be beneficial to enroll in that plan.

Does my doctor belong to the provider network for the plan I'm considering?

Call the medical plan's member services number to find out if your doctor is a participating physician, or call your doctor's office directly to find out which medical plans he or she contracts with.

The Comparison of Benefits charts found in this Guide show what the various medical plans cover for various types of services. By plotting out your anticipated needs throughout the year and then weighing them against your estimated monthly premium, copayment and deductible costs for each option, you will have a clearer picture of which plan may be best for you.

Also, be sure to look for the "Important Tip" boxes located throughout the Guide. They provide tips that can help you reduce your health care expenses, improve your health, or simply get the most out of your medical plan.

2005 Open Enrollment

This year's Open Enrollment period begins on **Monday, October 25, 2004, and ends on Friday, November 5, 2004.** During this time, you can make changes to your medical, dental, and vision coverage, and enroll in the reimbursement accounts for 2005. This Guide provides you with detailed enrollment information and descriptions of recent changes to the benefit plans offered to you through Pacific Gas and Electric Company. Use this information to make decisions regarding your benefits coverage for 2005.

If you have a LAN ID and computer access at work, you can enroll online. If you prefer, you can use the automated phone enrollment system.

ATTENTION ALL PROBATIONARY EMPLOYEES!

If you did not enroll in your health care benefit plans within 31 days of being hired, Open Enrollment is the time to do so, with coverage effective January 1, 2005. If you don't enroll now, you won't be given another opportunity to enroll in the health care plans or reimbursement accounts until next year's Open Enrollment period, unless you have an eligible change-in-status event before then (see page 15).

Who Needs to Enroll?

If you plan to make **any** changes to your health care coverage or contribute to either of the Reimbursement Accounts in 2005, you need to go through the enrollment process. Otherwise, you don't need to enroll. You will automatically receive the default coverage described on page 7. Just be sure to review the following:

- Your current medical plan's availability and monthly pre-tax cost for 2005, as shown on your Enrollment Worksheet;
- Your dependents' eligibility (see page 13);
- **What's New for 2005** (see pages 4 and 5); and
- Plan changes (indicated in bold on the Comparison of Benefits charts that begin on page 23).

Taking these easy steps will help ensure that your current health care coverage is still the best coverage for you!

IMPORTANT

Open Enrollment begins on **Monday, October 25, 2004**, and ends on **Friday, November 5, 2004.**

What's **NEW** for 2005

Blue Shield of California HMO

To provide you with more medical plan options, PG&E will offer a new plan in 2005 — the Blue Shield of California Access+ HMO plan. The Blue Shield Access+ HMO will offer access to many employees and retirees who currently do not have access to an HMO. Be sure to check your personalized 2005 Enrollment Worksheet to see if you are eligible for the Blue Shield Access+ HMO plan.

Before enrolling in the plan, it's a good idea to confirm whether your doctors or other providers participate in Blue Shield's Access+ HMO network. For a directory of participating providers or other information about the new Blue Shield Access+ HMO, please call Blue Shield at 1-800-443-5005 or visit its website at www.mylifepath.com.

Deductibles for NAP and CAP Plans Changing

As announced last year, there will be a new deductible for the Network Access Plan (NAP) and the Comprehensive Access Plan (CAP) next year. Effective January 1, 2005, all in-network services received under the NAP plan through preferred providers and all services of any type provided under the CAP plan will be subject to an annual deductible of $100 per person, with a $300 maximum deductible per family. NAP services provided by non-preferred providers will continue to be subject to an annual deductible of $200 per person, with a $600 maximum deductible per family. All deductibles will apply towards your annual medical plan out-of-pocket maximums.

Please note that these deductibles only apply to covered medical services received through the NAP and CAP medical plans. They do not apply to outpatient prescription drug purchases obtained through the Prescription Drug Plan administered by Medco Health, nor do they apply to the mental health/chemical dependency services received through the plan administered by ValueOptions. Deductibles, copayments, and out-of-pocket maximums for these plans are separate.

Other HMO Changes

Some of the HMOs are making changes to their service territories and primary care provider networks in 2005. The information presented here is as up-to-date as possible as of the publication date of these materials. However, because of the ongoing nature of these changes, we recommend that you verify the service area and provider availability directly with each HMO. Phone numbers for each plan are listed on the outside back cover of this Guide.

IMPORTANT TIP

Use your Health Care Reimbursement Account (HCRA) to lower the cost of your deductibles! Deductibles are an expense you can easily predict each year, so take advantage of the tax savings the HCRA can provide. You can also use the HCRA to help reduce the financial impact of copayments and other eligible health care expenses.

Medco By Mail — Same Rx Plan, New Name!

Medco Health, the company that manages prescription drug benefits for members enrolled in the UnitedHealthcare plans, is changing the name of its mail-order pharmacy service. Medco's "Home Delivery Pharmacy Service" will now be known as "Medco By Mail." Although the name of the mail-order service is changing, all of the plan benefits will remain the same, and you don't have to do anything differently to obtain prescriptions by mail.

Over the next few months, you may continue to see both the old name — Home Delivery Pharmacy Service — and the new name — Medco By Mail — until the transition has been completed.

New Magnetic ID Cards for UnitedHealthcare Members

All UnitedHealthcare members — both new and existing — will receive new membership identification cards in January 2005. The new cards will contain magnetic strips encoded with important information about your benefit coverage, such as copayment and coinsurance amounts, making it an easier, faster, and more accurate way for your health care providers to verify your membership and benefit details.

IMPORTANT

Be sure to check your 2005 Enrollment Worksheet to make sure your medical plan is still being offered where you live!

COBRA Changes

Cal-COBRA Update

- A recently enacted California bill — A.B. 245 — calls for the phasing out of the current California law commonly referred to as "Senior COBRA." Senior COBRA currently requires that extended COBRA continuation coverage be offered to certain HMO participants age 60 and older if their HMO coverage terminates. However, this special continuation coverage will no longer be offered to those participants who would otherwise have qualified for the coverage on or after January 1, 2005. Participants who are already receiving continuation coverage through Senior COBRA or those participants who qualified for Senior COBRA prior to January 1, 2005, will not be affected by this change.
- HMO members who exhaust their 18 months of federal COBRA coverage due to job termination or a reduction of work hours can extend COBRA coverage for another 18 months at 110%/150% of the normal premium. Members must contact their HMO for more information at least 60 days before their federal COBRA coverage expires.
- Cal-COBRA now allows HMO members who exhaust their 36 months of COBRA continuation coverage to apply for a HIPAA Guaranteed Issue individual plan. Members should contact their HMO for more information.

COBRA Extensions Due to Medicare-Entitlement

Previously, when a former or reduced-hour employee became eligible for Medicare while covered under an 18-month COBRA extension, family members who were qualified beneficiaries were considered eligible for an extension of COBRA benefits. Due to a recent IRS ruling, these family members will no longer be offered COBRA extensions when the primary member becomes eligible for Medicare.

What You Need to Do for Open Enrollment

Five Easy Steps

1 **Review your enclosed personalized 2005 Enrollment Worksheet.** The worksheet shows the plan options available to you for next year and your monthly pre-tax cost for each option. You may also review your enrollment options by logging into the online enrollment system and opening your personalized worksheet.

2 **Review your dependents' eligibility** (see page 13 for eligibility rules). If you have a dependent who is no longer eligible for coverage, be sure to remove the dependent from your health care coverage. If your dependent is about to lose eligibility, be sure to contact the HR Service Center as well, so your dependent can receive a COBRA continuation coverage enrollment package.

3 Review the information in this Enrollment Guide, especially the **What's New for 2005** section and **Comparison of Benefits Charts.**

IMPORTANT TIP

You can't participate in the Reimbursement Accounts for 2005 (HCRA and DCRA) unless you enroll, so think carefully before passing up on these valuable benefits!

4 **Decide whether you need to enroll:**

You **must enroll** if you want to:

- make plan changes [for example, if your current medical plan is no longer available in your area and you do not want to be automatically switched to the UnitedHealthcare plan (NAP or CAP) offered in your area;
- add or delete dependents;

  or
- contribute to either of the Flexible Spending Accounts — Health Care Reimbursement Account (HCRA) or Dependent Care Reimbursement Account (DCRA) — in 2005. Remember, any current HCRA or DCRA elections you have will not be carried over automatically into 2005, so think carefully before passing up these valuable benefits.

See **Before You Enroll** on page 10 for important things to consider prior to enrolling.

You **do not need to enroll** if:

- you want to keep the same medical, dental, and vision plan coverage and you have verified that your medical plan is still available in your area **OR** you want to keep the same dental and vision coverage, but your current medical plan will no longer be offered in 2005 and you want to be automatically switched to the UnitedHealthcare plan (NAP or CAP) shown on your Enrollment Worksheet;
- you do not need to add or delete any dependents;

  and
- you do not want to contribute to the HCRA or DCRA in 2005.

If you don't enroll, you will receive the Default Coverage described below.

5 To enroll, access the online enrollment system on the company intranet, or call the HR Service Center's automated phone system. See page 8 for information on how to enroll. Then see **After You Enroll** on page 11 for additional information.

IMPORTANT

Once you enroll, the plan coverage you choose stays in effect for the entire calendar year. You may not make changes before the next Open Enrollment period unless you have an eligible change-in-status event before then (see page 15).

DEFAULT COVERAGE

- Your current 2004 medical coverage*, if your plan is still available in 2005 where you live. However, if your current medical plan is not available — for example, if you recently moved — you will be switched to the appropriate UnitedHealthcare plan (NAP or CAP) available in your ZIP Code.
- Your current 2004 dental coverage*
- Your current 2004 vision coverage*
- No reimbursement account contributions

** for you and your covered dependents, as listed on your 2005 Enrollment Worksheet.*

How to Enroll

Enroll using either of the following two methods during the Open Enrollment period:

The HR Intranet Website:
wwwhr

If you have a LAN ID, you can enroll online by accessing the online enrollment system on the company's HR intranet website at wwwhr/aboutyou (or from PaGE ONE, select HR/About You). The HR website is available 24 hours every day on any computer which has access to the company intranet.

Please note: If you enroll online, you'll need to log on to your company e-mail a few days later to receive your confirmation statement, which will be sent electronically.

OR

The HR Service Center – Automated Phone System
Company Extension: 8-223-2363,
415-973-2363, or 800-788-2363

Enroll over the phone using the HR Service Center's automated phone system. The system is available 24 hours every day during Open Enrollment. If you need to speak to an HR Service Center representative, they are available by phone Monday through Friday from 7:30 a.m. until 5:30 p.m. Pacific Time during the Open Enrollment period.

Please use the company extension whenever possible. The "415" and "800" numbers are intended for employees to use only when a company number is not available. When an outside phone number is dialed from a company phone, the call ties up two phone lines (an external and an internal line).

Do not use portable, cellular or speaker phones to enroll. Also, be sure to go all the way through the call to confirm your selections. *If you hang up before you confirm your selections, they will not be recorded.*

Any changes you make during Open Enrollment will be effective January 1, 2005. Changes cannot be made after the Open Enrollment period ends on Friday, November 5, 2004.

Enroll online or over the HR Service Center's automated phone system between Monday, October 25th and Friday, November 5th.

PLEASE READ!

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

- ✓ acknowledge that you are responsible for reading the 2005 Enrollment Guide and reviewing your Confirmation Statement;
- ✓ authorize the Company to release your Social Security number to third-party administrators and insurers, as required, for purposes of plan administration;
- ✓ authorize the Company to deduct any required pre-tax contributions from your paycheck;
- ✓ acknowledge that you will not be able to change medical plans mid-year if your physician, hospital, medical group, or Independent Physician Association (IPA) terminates its relationship with your medical plan during 2005;
- ✓ acknowledge that your current HCRA/DCRA elections cannot automatically roll forward into 2005 and that you must actively re-enroll to make new HCRA/DCRA elections for 2005;
- ✓ acknowledge that the company 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;
- ✓ follow the appeal process for your plan for any disputed benefit claims; and
- ✓ call the HR Service Center to report any ineligible dependents within 31 days of a dependent's loss of eligibility.

Before You Enroll

If You're Considering Changing Medical Plans…

Make sure your doctors participate in the network of the plan you're considering. If there are any prescription medications you take on a regular basis, you should make sure these drugs are covered by the new plan, since covered drugs vary from plan to plan. It's also a good idea to verify the coverage offered for specific types of services that you and your family tend to use regularly (for example, chiropractic services or urgent care visits).

Selecting Primary Care Physicians (PCPs)

You are not required to select a primary care physician (PCP) if you enroll in the NAP or CAP plans. However, all of the HMOs, except Kaiser, require that you and your covered dependents each select a PCP from the plan's network of doctors. When you first enroll in one of these plans, the HMO will automatically assign a primary care physician to you and any dependents you enroll. You may select a different PCP upon receipt of your membership ID card(s) in January. Call your plan as soon as possible after you receive your ID card(s) and request that your physician selection(s) be made retroactive to January 1, 2005. Each plan has its own policy and time frames for changing primary care physicians retroactively.

For a directory of primary care physicians, call the member services number of the medical plan you're considering, or visit its website. Phone numbers and website addresses for the medical plans are listed on the back cover of this booklet.

Adding Eligible Dependents

You must have the following information for each dependent you wish to add:

- Name
- Date of birth
- Sex
- Social Security number

Adding Domestic Partners

If you wish to add a domestic partner and/or a domestic partner's child(ren) to your plan, your partnership must be registered with the company or a governmental agency such as the City of Berkeley. In addition, there may be tax implications for you. For further information regarding domestic partner registration and benefits, call the HR Service Center to obtain a copy of *Your Guide to Domestic Partner Benefits at Pacific Gas and Electric Company*, or access the guide on the company intranet (from PaGE ONE, select Human Resources/Benefits/Domestic Partnerships).

It is important to keep this Enrollment Guide and refer to it throughout the year.

After You Enroll

Making Changes After Open Enrollment

After the annual Open Enrollment period ends, you cannot make any changes to your plan coverage until a subsequent Open Enrollment period, unless one of the following events occurs:

- You have an eligible change-in-status event (see page 15 for detailed information);
- You move out of your HMO's service territory; or
- You retire.

Confirmation Statements

IBEW and SEIU Employees:

- If you enroll using the HR intranet, you will receive your confirmation statement by e-mail within 10 working days.
- If you enroll using the HR Service Center's automated phone system, you will receive a confirmation statement in the U.S. mail within 10 working days.
- If you don't make any changes during Open Enrollment, you will receive a confirmation statement in the U.S. mail by December 31, 2004, verifying your coverage for 2005.

ESC Employees:

- No matter which way you enroll (online or over the phone), you will receive your confirmation statement by e-mail within 10 working days.
- If you don't make any changes during Open Enrollment, you will receive a confirmation statement via e-mail by December 31, 2004, verifying your coverage for 2005.

Employees who are not actively at work will receive their confirmation statement at home via U.S. mail.

Membership Identification Cards

If you change medical plans or add dependents, you'll receive your new medical plan identification card(s) in January. As described on page 5, all UnitedHealthcare members will also receive new membership ID cards with magnetic strips in January 2005.

If you don't receive your new ID card(s) by the end of January, call your medical plan directly. If you or a dependent needs to see a doctor before your identification card arrives, you can use your confirmation statement as proof of coverage. Members of the UnitedHealthcare plans also have the option of printing a copy of their ID card from UnitedHealthcare's website at www.myuhc.com.

IMPORTANT

Whether or not you make any changes to your coverage, you should review your confirmation statement carefully to ensure it is accurate. If there is an error, call the HR Service Center immediately at 223-2363, 415-973-2363, or 800-788-2363.

Other Important Information and Resources

Health Plans Cover Mastectomy-Related Services

Effective January 1, 1999, the Women's Health and Cancer Rights Act of 1998 mandated that group health plans covering mastectomies pay for certain reconstructive and related services following a mastectomy. For a member who is receiving benefits under a plan in connection with a mastectomy and who elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

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

IMPORTANT TIP

UnitedHealthcare (UHC) medical plans offer a program called Cancer Resource Services (CRS) that helps covered members understand their cancer diagnosis and available treatment options, and provides access to premier cancer treatment centers to members with complex cancers. Call 866-936-6002 for additional information or help.

Employee Assistance Program (EAP)
888-445-4436

The Employee Assistance Program (EAP), provided to you by ValueOptions, is available 24 hours per day. This service, which is completely confidential and free of charge to you, can be a resource for such issues as:

- Marital and Family Problems
- Alcohol and/or Drug Problems
- Balancing Work and Family
- Depression
- Interpersonal Difficulties
- Stress/Anxiety
- Workplace Concerns
- Childcare/Eldercare Referrals
- Legal Concerns

You may also access the EAP online at: www.achievesolutions.net/pge

IMPORTANT TIP

Find Valuable Information About Your Benefits On the World Wide Web

Take advantage of our benefit plan vendors' Internet websites to access information about your personal benefit plans! Plan website addresses are listed on the outside back cover of this booklet. Some websites allow you to:

- ✓ Confirm eligibility for yourself and your dependents;
- ✓ Request new or replacement ID cards;
- ✓ Check the status of your claims online;
- ✓ Search for providers and/or switch primary care physicians;
- ✓ Check drug formulary information or order drug refills; and
- ✓ Learn about health and wellness topics, such as fitness and nutrition, pre-natal care, and disease management.

Eligibility

Who Is Eligible?

You are eligible for the company's benefit plans described in this booklet if you are a union-represented employee. You may also enroll your eligible dependents in the medical, dental and vision plans.

If you have any questions about whether or not a dependent is eligible for coverage, please check with the HR Service Center or your *Summary of Benefits Handbook.*

Eligible Dependents

Eligible dependents include:

- Your legally married spouse or registered domestic partner;
- Your unmarried, dependent children who are under age 19, including step-children, foster children, legally adopted children, and children for whom you have been permanently appointed legal guardianship by a court (does not include the legal wards of your spouse);
- The unmarried, dependent children of your registered domestic partner who are under age 19, including legally adopted children (a domestic partner's legal guardianship of a child is not included);
- Your unmarried, dependent children or those of your spouse/registered domestic partner who are age 19 through 23 and meet the IRS definition of an eligible dependent, whether or not you claim them as dependents on your income tax returns; or
- Your disabled dependent children or those of your spouse/registered domestic partner who are age 19 or older, who are certified as disabled by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) and who have been approved by the company for continued coverage (see **Disabled Dependents** in your *Summary of Benefits Handbook* for more information).

Note: If your spouse/registered domestic partner is also a company/PG&E Corporation employee or retiree, only one of you may enroll each child as a dependent in any one plan.

IMPORTANT

There are Penalties for Covering Ineligible Dependents

It is your responsibility to be sure all the dependents you enroll for coverage are eligible. Employees who cover ineligible dependents will be required to make restitution to the company for health care coverage up to $7,500 and may be subject to disciplinary action, up to and including discharge. If a dependent loses eligibility, he or she must be dropped within 31 days of loss of eligibility.

Dependent Certification

If you have a child who is between the ages of 19 and 23, please be aware that you may be asked to re-certify your child's status as an IRS-eligible dependent each year. **Dependents who lose eligibility during the year must be dropped within 31 days of the dependent's loss of eligibility.**

Domestic Partner Tax Certification

If you are covering a domestic partner and/or the child(ren) of a domestic partner, you must re-certify their tax dependency each year. If you don't receive a "Certification of Tax Dependency for Domestic Partnerships" form for the upcoming tax year, please call the HR Service Center to request a form.

National Medical Support Notices

If the company receives a court-ordered judgment or decree requiring you to cover an eligible dependent child, the child will be automatically 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 the company, and your health plan premiums will be adjusted, if applicable.

Ineligible Dependents

You must drop ineligible dependents within 31 days of the dependent's loss of eligibility. Ineligible dependents include, but are not limited to:

- A legally separated, divorced, or common-law spouse, even if a court orders you to provide health care coverage;
- A domestic partner, if your domestic partnership has not been formally registered with the appropriate government entity or the company's internal registry, or a former domestic partner;
- Parents, step-parents, parents-in-law, grandparents and step-grandparents;
- Former step-children or children of a former domestic partner, unless you have adopted them or have been appointed permanent legal guardianship by a court;
- Children age 19 through 23 who do not meet the current IRS definition of an eligible dependent;
- Children age 24 and over, unless they have been approved for continued coverage under the disabled dependent provision;
- Your disabled dependents if they have not been certified as disabled by a physician before they would otherwise cease to qualify as a dependent, and/or if they have not been approved by the company for continued coverage);
- Married children or children who have entered the military (regardless of age or disability status);
- Children covered as dependents under the plan of another company/PG&E Corporation employee or retiree;
- Grandchildren, nieces, nephews, or other family members unless you have legally adopted them or have been appointed permanent legal guardianship by a court; or
- A family member or domestic partner who is a company/PG&E Corporation employee or retiree who has his or her own coverage through the company/PG&E Corporation.

IMPORTANT

You must drop ineligible dependents within 31 days of the dependent's loss of eligibility.

Change-In-Status Events

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

- you have an eligible change-in-status event, or
- you retire.

IMPORTANT

Call the HR Service Center within 31 days of any eligible change-in-status event that may affect your benefits! Otherwise, you may not be able to add any dependents or change the amount you contribute to your Reimbursement Accounts until the next Open Enrollment period.

You may only make changes to your coverage that are consistent with your change-in-status event. For example, if you get married you may add your new spouse and stepchildren (if any); however, you cannot change plans. Correspondingly, if you move out of your HMO's service territory, you may change plans, but you cannot add new dependents.

PLEASE NOTE! The withdrawal of a provider (e.g., doctor, medical group, hospital, etc.) from your plan's network is not an eligible change-in-status event. If any of your providers withdraw from your medical plan's network, you must obtain services from a different provider within your plan's network for the rest of the year. You cannot change medical plans mid-year as a result of a provider's withdrawal.

Eligible Change in Status Events:

- Marriage or the establishment of a registered domestic partnership
- Dissolution of marriage (including final divorce or annulment), legal separation, or termination of a domestic partnership. Please note that you cannot cover your ex-spouse on your company-sponsored health care plans even if a court orders you to provide coverage.
- The birth or adoption of a child, or your court-ordered appointment of permanent legal guardianship for a child
- A change in your spouse's/registered domestic partner's or dependent's employment that results in a gain or loss of health care coverage
- A change to or from full-time or part-time employment by you or your spouse/registered domestic partner or dependents, if health plan eligibility is affected
- An unpaid leave of absence taken by you or your spouse/registered domestic partner that significantly impacts the cost of your benefits
- The death of your spouse/registered domestic partner or a dependent child
- Your dependent child reaching the plan's age limit, getting married, or entering the military
- Your dependent child regaining eligibility
- A change of caregivers, or a change in the cost for the services of a caregiver who is not a relative (for DCRA purposes only)
- A move out of your HMO's service territory (applies to change of medical plan only).

Move Out of HMO Service Area

If you move out of your HMO's service territory, you must call the HR Service Center within 31 days to select a new medical plan; otherwise, medical services you receive may not be covered. For more details, refer to your *Summary of Benefits Handbook*.

COBRA

When You, Your Spouse, or Your Other Dependents Lose Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows you or your covered dependents to continue participation in the Company's group health plans beyond the normal period if coverage is lost due to a "qualifying event," as defined by COBRA. Obtaining coverage through COBRA is at your own cost and may continue for a period of up to either 18 or 36 months, depending on the event.

COBRA Qualifying Events

- Your termination of employment (for any reason other than gross misconduct)
- Loss of your company-sponsored group health coverage due to a reduction in work hours
- A change in your employment status from full-time to part-time
- Your death while covered as a plan participant
- Divorce or legal separation from your spouse
- Loss of eligibility by your dependent child

The company extends the same type of coverage rights to registered domestic partners and their children that it would extend to qualified beneficiaries under COBRA. Qualifying events to obtain this COBRA-like coverage are the same as those for spouses, including the dissolution of a registered domestic partnership.

IMPORTANT

To request continued coverage through COBRA, you must submit a "Notice of Qualifying Event" form to the HR Service Center within 60 days of loss of coverage.

Qualified dependents must be covered under your plan prior to the actual qualifying event. Dependents who are taken off your coverage before the event may have their right to continued health care coverage through COBRA jeopardized. You may be held financially responsible for providing health coverage for dependents dropped prematurely.

Dependents who are dropped during the Open Enrollment process may not qualify for continued coverage under COBRA, since these rights are only triggered by certain qualifying events and specific notification to the company. If you are dropping a dependent during the Open Enrollment period and are not sure whether or not your dependent is eligible for COBRA due to a qualifying event, please contact the HR Service Center. To request continued coverage through COBRA, you must submit a "Notice of Qualifying Event" form to the HR Service Center within 60 days of loss of coverage.

For complete information on COBRA eligibility and qualifying events, please refer to your *Summary of Benefits Handbook.*

If Your HMO Coverage Through COBRA Ends

For those qualified individuals who, on or after January 1, 2003, had a COBRA qualifying event that allowed for 18 months of continuation coverage under federal law, California law (Cal-COBRA) allows an additional 18 months of continuation coverage through your HMO upon the exhaustion of your federal COBRA coverage. 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 time frame. For application materials, cost, or additional information, contact your HMO at least 60 days before your federal COBRA coverage terminates.

Please note that Cal-COBRA's Senior COBRA continuation coverage is no longer available. Participants who are already receiving continuation coverage through Senior COBRA or those participants who qualified for Senior COBRA prior to January 1, 2005, will not be affected by this change.

Dental Coverage

The Dental Plan is administered by Delta Dental. You generally will save money if you use a dentist who participates in the Delta Dental network. Delta typically uses a higher reimbursement rate for participating dentists. If you choose to use a non-participating dentist, Delta may base its payment on a much lower reimbursement rate. You will be responsible for the difference between the fees actually submitted by the non-participating dentist and the potentially lower reimbursement rate as determined by Delta, in addition to your deductible and coinsurance.

If your dentist (whether a participating dentist or not) recommends extensive dental work, such as a crown, root canal, or bridge, ask your dentist to file a "predetermination" in advance of receiving the services. Delta will provide a predetermination claim notice to both you and your dentist. This notice will let you know if the procedure will be covered and, if so, your estimated share of the cost.

For a list of Delta's dentists, call Delta Dental at 888-217-5323 or check its website at www.deltadentalca.org.

All plan benefits are subject to Delta Dental's usual, customary and reasonable allowances.

Delta Plan Benefits	
Choice of dentist	Any; for maximum benefits, use a Delta Dentist
Annual deductible	$50 per individual up to a family maximum of $150 for all covered services other than preventive and diagnostic services
Plan covers	85% of eligible preventive*, basic and major care
Annual maximum	$2,000 per individual (excludes orthodontia treatment)
Orthodontia	50% up to $1,500 per individual lifetime benefit

** Includes cleanings and routine checkups twice in any calendar year, plus periodic X-rays and fluoride treatments*

IMPORTANT TIP

Remember, you can use the Health Care Reimbursement Account (HCRA) for anticipated dental expenses not covered by the plan, including deductibles, coinsurance, uncovered orthodontia costs, etc. Using the HCRA lowers your taxable income, which in turn lowers your tax bill for the year.

Vision Coverage

The Vision Plan is administered by Vision Service Plan (VSP). You have the option of using doctors in the VSP network or doctors of your own choice. You will generally pay less when you use a VSP provider. If you use a provider who is not in the VSP network, you pay the bill in full and VSP will reimburse you based on a schedule of benefits.

For a list of VSP providers, call VSP at 800-877-7195 or check its website at www.vsp.com. When making an appointment, be sure to identify yourself as a VSP member.

Vision Plan Benefits	
Choice of doctor	Any; for maximum benefits, use a VSP member doctor
Copayments with VSP doctor (applicable to each covered person)	$10 vision exam $25 materials (lenses and frames)*
Plan benefits with VSP doctor	■ **Vision Exams** – Every 12 months ■ **Eyeglass Lenses** – Every 12 months ■ **Frames** – Every 24 months ■ **Contact Lenses, Elective & Visually Necessary** – Every 12 months in lieu of all other lens and frame benefits. When contact lenses are obtained, the covered person shall not be eligible for lenses again for 12 months and frames for 24 months. ● **Elective** – Covered up to $75 towards purchase and exam. If contact lenses are not obtained through prescribing doctor, member may be required to pay contact lens evaluation and fitting fee. ● **Visually Necessary** – Covered in full **only** with prior authorization from VSP and when obtained from a participating doctor.

** Member is responsible for charges in excess of the Plan's allowable expenses in addition to the cost of cosmetic extras not covered by the Plan, such as blended, tinted or oversized lenses, etc.*

IMPORTANT TIP

Remember, you can use the Health Care Reimbursement Account (HCRA) for anticipated vision care expenses not covered by the plan, including copayments, costs for materials that exceed the plan's benefits, elective surgery, etc. Using the HCRA lowers your taxable income, which in turn lowers your tax bill for the year.

Reimbursement Accounts

(Flexible Spending Accounts)

Among the many valuable benefits the company offers to you are **the Health Care Reimbursement Account (HCRA) and the Dependent Care Reimbursement Account (DCRA).** These reimbursement accounts — also referred to as Flexible Spending Accounts, or "FSAs" — offer you a way to save on taxes for certain out-of-pocket health care and/or dependent care expenses. The HCRA and DCRA are separate; you may sign up for either or both. Both accounts are administered by UnitedHealthcare.

Any salary contributions you make will reduce your taxable income. The minimum contribution to each account is $50 per year. During the plan year, when you incur an eligible expense, you may pay the provider and then file a claim for reimbursement from your account — which reimburses you with pre-tax dollars. UnitedHealthcare members enrolled in the HCRA can elect to take advantage of the Automatic Reimbursement feature which automatically forwards any eligible out-of-pocket medical and/or Medco Health prescription drug expense claims (copayments, coinsurance, deductibles, etc.) to UnitedHealthcare for reimbursement through your HCRA. In addition, all employees who elect to contribute to either the HCRA or DCRA may choose to have their reimbursement checks directly deposited to the banking institution of their choice.

If you do not use all of the funds in your reimbursement account(s) for the plan year, you will forfeit the remaining amount. Expenses must be incurred during the plan year in which you elect to contribute. You have until March 31 of the following year to submit claims for expenses incurred in the previous year.

If you want to begin participating in the HCRA or DCRA, or if you're currently participating in either type of account and you want to continue contributing in 2005, you **must** enroll during Open Enrollment to indicate the *annual* amount you want to contribute.

> Your HCRA/DCRA elections for 2004 cannot be carried over automatically into 2005.

Health Care Reimbursement Account (HCRA)

Having an HCRA allows you to pay for certain out-of-pocket health care expenses (such as hearing aids, contact lens solution, or health plan deductibles and copayments) on a pre-tax basis. During Open Enrollment, you estimate what your total out-of-pocket expenses will be for the upcoming year for yourself and your IRS-eligible dependents — even if they are not enrolled in the company's health plans. You authorize the company to deduct that amount (not to exceed $5,000) from your paycheck on a pre-tax basis.

Be sure to estimate your potential health care expenses carefully, since unused HCRA contributions will be forfeited.

Eligible expenses are generally the same as those approved by the IRS for tax deduction purposes, **except for premium contributions, which are not eligible for reimbursement through the HCRA.** For a list of what the IRS allows as eligible expenses, refer to *IRS Publication 502, Medical and Dental Expenses,* available directly from the IRS by calling 800-829-3676 or on the IRS Internet website at www.irs.gov. In addition, although the IRS does not allow over-the-counter or "OTC" (i.e, non-prescription) drug expenses for tax deduction purposes, some OTC drugs may be eligible for reimbursement through the HCRA. Please contact UnitedHealthcare for information on which OTC drugs may be eligible for reimbursement.

Mid-Year Changes in HCRA Contributions

You may increase or decrease your HCRA annual contribution goal during the year only if you have certain eligible change-in-status events and your change in contribution is consistent with the status change. For example, if you get a divorce and you no longer expect to pay health care expenses for your former spouse, you may decrease your HCRA, but you cannot increase it. Please note that a change in the cost of your health insurance coverage does not constitute a valid reason to make a mid-year change in the amount you contribute.

If you begin contributing mid-year after an eligible change-in-status event, expenses incurred before you began contributing are not eligible for reimbursement.

IMPORTANT TIP

Some over-the-counter (OTC) drugs, like aspirin and cold medicine, are eligible for reimbursement through PG&E's Health Care Reimbursement Account (HCRA). Check with UnitedHealthcare in advance to verify if specific OTC drugs you purchase may be reimbursable and, if so, what documentation will be required.

Dependent Care Reimbursement Account (DCRA)

Both the DCRA and the Federal Dependent Care Income Tax Credit can lower your taxes, but in different ways. If you have more than one child, under certain circumstances you may use both methods. Otherwise, you may only use one of the two methods. Your tax advisor can help you decide how to maximize your tax savings. If you are married, both spouses must be actively at work or attending school (unless one of you is disabled) for a DCRA expense to be valid. If one spouse is at home (for example, on a maternity leave), expenses incurred for day care are not eligible for reimbursement. In addition, day care expenses must not exceed your salary or, if you are married, your spouse's salary. Refer to the *IRS Publication 503, Child and Dependent Care Expenses,* available on the IRS website at www.irs.gov, or call the IRS at 800-829-3676 to obtain the publication.

Mid-Year Changes in DCRA Contributions

You may make a change in the annual amount you contribute only if you have an eligible change-in-status event (such as the birth or adoption of a child), and your change in contributions is consistent with the status change. You may also make a corresponding change to your DCRA if you replace one dependent care provider with another or if there is a change in the cost for the services of *a caregiver who is not a relative.* For example, if you want to change from using a day care center to employing an aunt to watch your child, an election change would be permitted even though the aunt is related to you. If, however, you decide to give your aunt a raise, you may not make a mid-year election change to reflect the raise. The IRS will not allow a mid-year change to your DCRA for a change in the fee charged by a relative.

If you begin contributing mid-year after an eligible change-in-status event, expenses incurred before you began contributing are not eligible for reimbursement.

How Much Can You Contribute Each Year?

Reimbursement Account	Annual Contribution Amount
Health Care	$5,000 maximum per individual or married couple filing a joint tax return (married individuals filing separate income tax returns may each contribute up to $5,000).
Dependent Care	$5,000 maximum per individual or married couple filing a joint tax return (married individuals filing separate income tax returns may each contribute up to $2,500). Your annual contributions to the dependent care account cannot exceed your spouse's income. If your spouse is a full-time student or is mentally or physically disabled, he or she is considered to have an annual income of $2,400 if you have one eligible child or $4,800 if you have more than one child.

Comparison of Prescription Drug Benefits

For UnitedHealthcare Plans (Administered by Medco Health)

The following table summarizes the prescription drug benefits for members enrolled in the UnitedHealthcare NAP and CAP plans. Plan benefits are administered by Medco Health. Please note that the Medco Health out-of-pocket maximum does not coordinate with the UnitedHealthcare out-of-pocket maximum.

For general information regarding the prescription drug coverage provided by each HMO, refer to **Outpatient Prescription Drugs** on the Comparison of Benefits charts that follow. For more specific information about an HMO's drug coverage, call the HMO's member services department directly or visit its website at the Internet address listed on the outside back cover.

Provisions	NAP and CAP Plans
Retail Drug Purchases	First three 30-day supplies at a participating pharmacy: 85% for generics, 75% for brand names. Generic Incentive Provision applies (see below). Refills beyond 90 days and coverage at non-participating pharmacies: 80% for generics and 70% for brand names. Generic Incentive Provision applies (see below).
Home Delivery (Mail-Order) Purchases	90% for generic drugs and 80% for brand name drugs. Generic Incentive Provision applies (see below).
Generic Incentive Provision	Member is responsible for paying the difference between the price of a generic drug and a brand-name drug, plus coinsurance, if purchasing a brand-name drug when a generic version is available. Please note that any generic-brand price differential you pay is a non-covered expense and, thus, does **not** count towards your annual out-of-pocket maximum (see below). Drugs that are listed on Medco Health's "Narrow Therapeutic List" will be excluded from this mandatory generic provision.
Deductible	No deductible
Annual Out-of-Pocket Maximum	$500 per person, $1,000 per family. Out-of-pocket maximum coordinates the retail drug benefit with the home delivery drug benefit, but does not coordinate with medical plan. Non-covered expenses, such as generic-brand price differentials, are not eligible expenses and, thus, will not be covered by the plan after your annual out-of-pocket maximum is met.
Lifetime Maximum	No lifetime maximum
Infertility, Sexual Dysfunction, Memory Enhancement and Contraceptive Drugs	50% for both retail and home delivery drugs, unless medically necessary. Medically necessary drugs are covered at standard reimbursement rates. Generic Incentive Provision applies (see above).

Comparison of Benefits Chart

Bargaining Unit

This benefit chart is a summary only. Refer to your health plan's Evidence of Coverage (EOC) for details. The EOC is the binding document between the health plan and its members. In case of conflict between the benefit chart and the EOC, the EOC will prevail.

Provisions	Blue Shield Access+ HMO	Health Net
General	Members access the Blue Shield HMO network	Only providers affiliated with Health Net HMO
Hospital Stay	No charge	No charge; includes intensive and coronary care.
Skilled Nursing Facility	No charge; 100-day limit.	No charge; 100-day limit.
Emergency Room Care	$25/visit for emergencies (waived if admitted). Member needs to contact PCP within 24 hours of service.	$25/visit for emergencies (waived if admitted). Must notify Health Net within 48 hours.
Outpatient Hospital Care	$10/visit	$10/visit
Maternity Care	No charge	No charge
Well-Baby Care	$10/visit	$10/visit
Office Visits	Office visit – $10; $30 without referral (Access+ Specialist) – must be in the same Medical Group or IPA; Home visit – $10	Office visit – $10 Home visit – $10
Urgent Care Visits	$10/visit	$10/visit
Routine Physical Examinations	$10/visit according to health plan schedule	$10/visit for basic Periodic Health Evaluation
Immunizations and Injections	No charge	Included in office visit. Injections related to infertility services covered at 50%.
Eye Examinations	$10/visit for refraction	$10/visit
X-rays and Lab Tests	No charge	No charge
Pre-Admission Testing	No charge	No charge
Home Health Care	No charge	No charge
Hospice Care	No charge	**No charge**
Outpatient Physical Therapy	$10/visit; as long as continued treatment is medically necessary pursuant to the treatment plan.	$10/visit; provided as long as significant improvement is expected.
Outpatient Prescription Drugs	Retail drugs (up to 30-day supply): $5 copay for generic formulary, $15 copay for brand formulary, and $35 copay for non-formulary. Some drugs require preauthorization. Mail-order drugs (through the plan): two times retail copay for up to a 90-day supply. No annual maximum; open formulary.	Retail drugs (up to 30-day supply): $5 copay for **primarily** generic formulary, $15 copay for **primarily** brand formulary, and $35 for non-formulary. Some drugs require preauthorization. Mail-order drugs (through the plan): two times retail copay for up to a 90-day supply. No annual maximum; open formulary.
Mental Health*		
Inpatient Care	Severe mental illness (same as parity diagnosis): No charge; no day limit. Other mental illnesses: No charge for up to 30 days/calendar year for crisis intervention.	Severe mental illness (same as parity diagnosis): No charge; no day limit. Other mental illnesses: No charge for up to 30 days/calendar year for crisis intervention.
Outpatient Care	Severe mental illness (same as parity diagnosis): $10/visit; no visit limit. Other mental illnesses: $20/visit; 20 visits per calendar year.	Severe mental illness (same as parity diagnosis): $10/visit; no visit limit. Other mental illnesses: $20/visit; 20 visits per calendar year.
Alcohol and Drug Care		
Inpatient Care	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions
Outpatient Care	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions
Durable Medical Equipment	No charge; preauthorization required. See plan EOC for limitations and exclusions.	No charge; preauthorization required. See plan EOC for limitations and exclusions.
Chiropractic Care	Not covered	Not covered
Acupuncture	Not covered	Not covered
Other Benefits	Infertility treatment – 50% of covered services, including drugs and laboratory. See plan EOC for detailed coverage.	Infertility treatment – 50% of covered services, including drugs and laboratory. See plan EOC for detailed coverage.

Coverage for mental health is provided through the HMO only, not ValueOptions

*Changes for 2005 are in **bold-faced** type*

Comparison of Benefits Chart

Bargaining Unit

This benefit chart is a summary only. Refer to your health plan's Evidence of Coverage (EOC) for details. The EOC is the binding document between the health plan and its members. In case of conflict between the benefit chart and the EOC, the EOC will prevail.

Provisions	Kaiser Permanente North	Kaiser Permanente South
General	Services provided at Kaiser Permanente Hospitals and Offices by Kaiser Permanente doctors	Services provided at Kaiser Permanente Hospitals and Offices by Kaiser Permanente doctors
Hospital Stay	No charge; includes intensive and coronary care.	No charge; includes intensive and coronary care.
Skilled Nursing Facility	No charge to members in service area for up to 100 days per benefit period when prescribed by a plan physician. Not covered for members living outside of service area.	No charge to members in service area for up to 100 days per benefit period when prescribed by a plan physician. Not covered for members living outside of service area.
Emergency Room Care	$25/visit for emergencies (waived if admitted). Must notify Kaiser within 24 hours.	$25/visit for emergencies (waived if admitted). Must notify Kaiser within 24 hours.
Outpatient Hospital Care	$10 per procedure for outpatient surgery; $10/visit for all other outpatient services may apply.	$10 per procedure for outpatient surgery. $10/visit for all other outpatient services may apply.
Maternity Care	No charge	No charge
Well-Baby Care	$10/visit	$10/visit
Office Visits	Office visit – $10 Home visit – No charge	Office visit – $10 Home visit – No charge
Urgent Care Visits	$10/visit	$10/visit
Routine Physical Examinations	$10/visit	$10/visit
Immunizations and Injections	$10/visit for immunizations & allergy testing if no office visit; $5/visit for allergy injections if no office visit.	$10/visit for immunizations & allergy testing if no office visit; $5/visit for allergy injections if no office visit.
Eye Examinations	$10/visit for screening/refraction; lenses and frames not covered.	$10/visit for screening/refraction; lenses and frames not covered.
X-rays and Lab Tests	No charge	No charge
Pre-Admission Testing	No charge	No charge
Home Health Care	No charge to members in service area when prescribed by a plan physician. Not covered for members living outside of service area.	No charge to members in service area when prescribed by a plan physician. Not covered for members living outside of service area.
Hospice Care	No charge to members in service area when prescribed by a plan physician. Not covered for members living outside of service area.	No charge to members in service area when prescribed by a plan physician. Not covered for members living outside of service area.
Outpatient Physical Therapy	$10/visit; therapy is given if in the judgment of a plan physician significant improvement is achievable.	$10/visit; therapy is given if in the judgment of a plan physician significant improvement is achievable.
Outpatient Prescription Drugs	$10 copay for up to 100-day supply when obtained at a plan pharmacy or through the plan's mail-order; no annual maximum; closed formulary.	$10 copay for up to 100-day supply when obtained at a plan pharmacy or through the plan's mail-order; no annual maximum; closed formulary.
Mental Health*		
Inpatient Care	No charge for up to 30 days per calendar year; no day limit for mental health parity diagnoses.	No charge for up to 30 days per calendar year; no day limit for mental health parity diagnoses.
Outpatient Care	$10/visit (individual), $5/visit (group) for up to 20 visits per calendar year; no visit limit for mental health parity diagnoses.	$10/visit (individual), $5/visit (group) for up to 20 visits per calendar year; no visit limit for mental health parity diagnoses.
Alcohol and Drug Care		
Inpatient Care	No charge for detoxification. Also covered by separate Alcohol and Drug Care Program with referral by ValueOptions (inpatient only).	No charge for detoxification. Also covered by separate Alcohol and Drug Care Program with referral by ValueOptions (inpatient only).
Outpatient Care	$10/visit (individual); $5/visit (group)	$10/visit (individual); $5/visit (group)
Durable Medical Equipment	No charge to members in service area when prescribed by a plan physician. See plan EOC for limitations and exclusions. Not covered for members living outside of service area.	No charge to members in service area when prescribed by a plan physician. See plan EOC for limitations and exclusions. Not covered for members living outside of service area.
Chiropractic Care	Not covered	Not covered
Acupuncture	Not covered	Not covered
Other Benefits	Infertility treatment – 50% of covered services, including drugs and laboratory. See plan EOC for detailed coverage.	Infertility Treatment – 50% of covered services, including drugs and laboratory. See plan EOC for detailed coverage.

Coverage for mental health is provided through the HMO only, not ValueOptions

Changes for 2005 are in ***bold-faced*** *type*

Comparison of Benefits Chart

Bargaining Unit

This benefit chart is a summary only. Refer to your health plan's Evidence of Coverage (EOC) for details. The EOC is the binding document between the health plan and its members. In case of conflict between the benefit chart and the EOC, the EOC will prevail.

Provisions	PacifiCare
General	Only providers affiliated with PacifiCare HMO
Hospital Stay	No charge for semi-private room; includes intensive and coronary care.
Skilled Nursing Facility	No charge; 100 days per calendar year from first treatment, per disability.
Emergency Room Care	$25/visit for emergencies (waived if admitted as an inpatient). Must notify PacifiCare within 24 hours.
Outpatient Hospital Care	$50/visit
Maternity Care	No charge
Well-Baby Care	$10/visit
Office Visits	Office visit – $10 Home visit – $10
Urgent Care Visits	$25/visit
Routine Physical Examinations	$10/visit
Immunizations and Injections	Included in office visit
Eye Examinations	$10 copay for vision screening/refractions; lenses and frames not covered.
X-rays and Lab Tests	No charge
Pre-Admission Testing	No charge
Home Health Care	No charge, **up to 100 visits per calendar year.**
Hospice Care	No charge up to 180 days per lifetime in a facility or on an outpatient basis
Outpatient Physical Therapy	$10/visit; unlimited visits
Outpatient Prescription Drugs	RETAIL (up to 30-day supply): $5 copay for generic formulary, $15 copay for brand formulary, and $35 copay for non-formulary; no annual maximum; open formulary. MAIL-ORDER (through the plan): two times retail copay for 90-day supply; no annual maximum; open formulary. **$50 self-injectable medication copay for 30-day supply**
Mental Health*	
Inpatient Care	No charge up to 30 days per calendar year (unlimited days for parity diagnosis).
Outpatient Care	$20/visit up to 20 visits per calendar year for non-parity diagnoses. Severe mental illness (same as parity diagnoses): no visit limit for outpatient care at $10.
Alcohol and Drug Care	
Inpatient Care	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions
Outpatient Care	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions
Durable Medical Equipment	No charge; preauthorization required. See plan EOC for limitations and exclusions. **$5,000 annual maximum per calendar year.**
Chiropractic Care	Discounts available through "PERKS" program. Contact PacifiCare for details.
Acupuncture	Discounts available through "PERKS" program. Contact PacifiCare for details.
Other Benefits	Infertility Treatment – 50% of covered services, including drugs and laboratory. See plan EOC for detailed coverage.

Coverage for mental health is provided through the HMO only, not ValueOptions

Comparison of Benefits Chart

Bargaining Unit

The information in this chart is intended as a summary only. The applicable legal documents will govern actual benefits.

Provisions	Comprehensive Access Plan (CAP) Administered by UnitedHealthcare
General	May use provider of choice or network providers; **$100 annual deductible per individual, up to family maximum of $300**; annual out-of-pocket maximum of $750 per individual, up to family maximum of $1,500 (includes deductible); no lifetime maximum *All plan benefits and out-of-pocket maximums are based on Eligible Expenses only.**
Hospital Stay	100% after a $100 copayment; preauthorization required for non-emergency care, $300 penalty if not obtained; covers semi-private room (private if Medically Necessary); includes intensive care
Skilled Nursing Facility	90% for semi-private room after 3 days in hospital; preauthorization required, $300 penalty if not obtained
Outpatient Hospital and Emergency Room Care	100% after $35 copay for medical emergency or outpatient surgery; waived if admitted
Maternity Care	Covered as any other condition. Preauthorization of delivery stays beyond 48 hours for normal delivery and 96 hours for cesarean section; $300 penalty if not obtained
Well-Baby Care	Covered as any other condition
Office Visits	Primary care – 100% after $10 copay; Specialist (including OB/GYN) – 100% after $20 copay
Urgent Care Visits	Primary care – 100% after $10 copay; Specialist (including OB/GYN) – 100% after $20 copay
Routine Physical Examinations	Primary care – 100% after $10 copay; Specialist – 100% after $20 copay; lab/X-ray covered separately
Immunizations and Injections	95%
Eye Examinations	Not covered
X-rays and Lab Tests	90%
Pre-Admission Testing	95%
Home Health Care	90%; requires prior authorization; $300 penalty if not obtained
Hospice Care	90%; requires prior authorization; $300 penalty if not obtained
Outpatient Physical Therapy	80%
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health. See page 22 for details.
Mental Health Inpatient Care Outpatient Care	Covered by separate Mental Health Program ■ 100% with referral by ValueOptions; 50% without referral ■ $15/visit with referral by ValueOptions, no charge for initial visit to psychiatrist (M.D.) for medication evaluation; 50% without referral; up to 30 visits per year
Inpatient and Outpatient Alcohol and Drug Care	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions
Durable Medical Equipment	80%; preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained
Chiropractic Care	80% for Medically Necessary care only; preauthorization by ASHN required after initial visit
Acupuncture	80% for up to 20 visits per year from licensed acupuncturist or M.D.
Other Benefits	Infertility – Paid according to type of benefit; $7,000 lifetime maximum. Balances from prior plans carry forward. Transplant Services – 100%, preauthorization and use of Designated United Resource Network Facility required

** "Eligible Expenses" are: (1) expenses for Covered Health Services that are covered by the plan; (2) those that UnitedHealthcare considers "Medically Necessary" for the diagnosis or treatment of an illness or injury; and (3) those that do not exceed the "Reasonable and Customary" rate as determined by UnitedHealthcare. Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call UnitedHealthcare Member Services.*

*Changes for 2005 are in **bold-faced** type*

Comparison of Benefits Chart

Bargaining Unit

The information in this chart is intended as a summary only. The applicable legal documents will govern actual benefits.

Provisions	Network Access Plan (NAP) Administered by UnitedHealthcare	
	Network	**Non-Network**
General	Care provided by network providers. **$100 annual deductible per individual, up to family maximum of $300;** annual out-of-pocket maximum of $750 per individual, up to family maximum of $1,500 (includes deductible); no lifetime maximum on benefits.	Care provided by non-network providers. $200 annual deductible per individual, up to family maximum of $600; annual out-of-pocket maximum of $1,000 per individual, up to family maximum of $2,000 (includes deductible); no lifetime maximum. *All plan benefits and out-of-pocket maximums are based on Eligible Expenses only.**
Hospital Stay	100% after $100 copay; preauthorization required for non-emergency care, $300 penalty if not obtained; covers semi-private room (private if Medically Necessary); includes intensive care.	70%; preauthorization required for non-emergency care, $300 penalty if not obtained; covers semi-private room (private if Medically Necessary); includes intensive care.
Skilled Nursing Facility	90% for semi-private room after 3 days in hospital; preauthorization required, $300 penalty if not obtained.	70% for semi-private room after 3 days in hospital; preauthorization required, $300 penalty if not obtained.
Outpatient Hospital and Emergency Room Care	100% after $35 copay for medical emergency or outpatient surgery; waived if admitted.	100% after $35 copay for emergency room care, waived if admitted; 70% for outpatient surgery.
Maternity Care	Covered as any other condition. Preauthorization of delivery stays beyond 48 hours for normal delivery and 96 hours for cesarean section; $300 penalty if not obtained.	Covered as any other condition. Preauthorization of delivery stays beyond 48 hours for normal delivery and 96 hours for cesarean section; $300 penalty if not obtained.
Well-Baby Care	Covered as any other condition	Covered as any other condition
Office Visits	Primary care – 100% after $10 copay; Specialist (including OB/GYN) – 100% after $20 copay	70%
Urgent Care Visits	Primary care – 100% after $10 copay; Specialist (including OB/GYN) – 100% after $20 copay	70%
Routine Physical Examinations	Primary care – 100% after $10 copay; Specialist – 100% after $20 copay; lab/X-ray covered separately.	70%
Immunizations and Injections	95%	70%
Eye Examinations	Not covered	Not covered
X-rays and Lab Tests	90%	70%
Pre-Admission Testing	95%	70%
Home Health Care	90%; requires prior authorization; $300 penalty if not obtained.	70%; requires prior authorization; $300 penalty if not obtained.
Hospice Care	90%; requires prior authorization; $300 penalty if not obtained.	70%; requires prior authorization; $300 penalty if not obtained.
Outpatient Physical Therapy	80%	70%
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health. See page 22 for details.	Covered by separate drug plan administered by Medco Health. See page 22 for details.
Mental Health Inpatient Care Outpatient Care	Covered by separate Mental Health Program ■ 100% with referral by ValueOptions; 50% without referral. ■ $15/visit with referral by ValueOptions, no charge for initial visit to psychiatrist (M.D.) for medication evaluation; 50% without referral; up to 30 visits per year.	Covered by separate Mental Health Program ■ 100% with referral by ValueOptions; 50% without referral. ■ $15/visit with referral by ValueOptions, no charge for initial visit to psychiatrist (M.D.) for medication evaluation; 50% without referral; up to 30 visits per year.
Inpatient and Outpatient Alcohol and Drug Care	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions	Covered by separate Alcohol and Drug Care Program with referral by ValueOptions
Durable Medical Equipment	80%; preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained.	70%; preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained.
Chiropractic Care	80% for care approved by ASHN using ASHN provider	70% for up to 15 visits for Medically Necessary care
Acupuncture	80% for up to 20 visits per year from licensed acupuncturist or M.D.	70% for up to 15 visits per year from licensed acupuncturist or M.D.
Other Benefits	Infertility – Paid according to type of benefit; $7,000 lifetime maximum. Balances from prior plans carry forward. Transplant Services – 100% when performed at a Designated United Resource Network Facility; preauthorization required.	Infertility – Paid according to type of benefit; $7,000 lifetime maximum. Balances from prior plans carry forward. Transplant Services – 70% if not performed at a Designated United Resource Network Facility; preauthorization required.

** "Eligible Expenses" are: (1) expenses for Covered Health Services that are covered by the plan; (2) those that UnitedHealthcare considers "Medically Necessary" for the diagnosis or treatment of an illness or injury; and (3) those that do not exceed the "Reasonable and Customary" rate as determined by UnitedHealthcare. Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call UnitedHealthcare Member Services.*

HMO Availability Chart

This chart lists the HMO plans offered in selected counties in California. Plan availability is based on ZIP codes and may be limited in some counties. Please call each HMO directly if you would like to verify its availability in your ZIP code.

● = Coverage in Entire County ▲ = Coverage in Some Parts of County

County	Blue Shield	Health Net	Kaiser North & South	PacifiCare
Alameda	●	●	●	●
Amador			▲	
Butte	●			
Colusa				
Contra Costa	●	●	●	●
El Dorado	▲	▲	▲	▲
Fresno	●	▲	▲	●
Glenn				
Humboldt				
Imperial			▲	▲
Kern	▲	▲	▲	●
Kings	●	●	▲	●
Lake				
Los Angeles	●	●	▲	▲
Madera	●	●	▲	▲
Marin	●	●	●	▲
Mariposa			▲	
Mendocino				
Merced	●	●		●
Monterey				
Napa		●	▲	
Nevada	▲	▲		▲
Orange	●	●	●	●
Placer	▲	▲	▲	▲
Plumas				
Riverside	●	▲	▲	▲
Sacramento	●	●	●	●
San Bernardino	▲	▲	▲	▲
San Diego	▲	●	▲	●
San Francisco	●	●	●	●
San Joaquin	●	●	●	●
San Luis Obispo	●			●
San Mateo	●	●	●	●
Santa Barbara	●	●		●
Santa Clara	●	●	▲	●
Santa Cruz	●	●		●
Sierra				
Solano	●	●	●	●
Sonoma	●	●	▲	●
Stanislaus	●	●	●	●
Sutter			▲	
Tehama				
Tulare	●	●	▲	●
Ventura	●	●	▲	●
Yolo	●	●	▲	●
Yuba			▲	

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Where to Get Help

Topic	Contact	Phone Number / Web Site
Questions About Enrollment or Benefits	PG&E HR Service Center	Co. Ext. 223-2363, 415-973-2363, or 800-788-2363
	E-Mail Address	HRBenefitsQuestions@pge.com
	HR Web Site	wwwhr
	or refer to your *Summary of Benefits Handbook*	
IRS Publications	IRS	800-829-3676 or www.irs.gov

Member Services Numbers

For information or provider directories, call the appropriate plan's number or visit its website.

Plan	Phone Number	Web Site
Blue Shield of California	800-443-5005	www.mylifepath.com
Dental Plan (Administered by Delta Dental)	888-217-5323	www.deltadentalca.org
Employee Assistance Program	888-445-4436	wwwhr/benefits
Health Net	800-522-0088	www.healthnet.com
Kaiser Permanente (North and South)	800-464-4000	my.kaiserpermanente.org/ca/pge
PacifiCare	800-624-8822	www.phs.com
PG&E Medical Plans (Administered by UnitedHealthcare)	877-842-4743	www.provider.uhc.com/pge *or* www.myuhc.com
Network Access Plan (NAP)		
Comprehensive Access Plan (CAP)		
American Specialty Health Network	800-678-9133	www.ashplans.com
Cancer Resource Services (CRS)	866-936-6002	www.urncrs.com
Nurse Advice Line	877-842-4743, then select Option 3	
Mental Health, Alcohol and Drug Care Program (Administered by ValueOptions)	800-562-3588	www.valueoptions.com
Prescription Drug Plan (Administered by Medco Health)	800-718-6590	www.medcohealth.com
Reimbursement Accounts (Administered by UnitedHealthcare)	877-842-4743	www.myuhc.com
Vision Plan (Administered by Vision Service Plan)	800-877-7195	www.vsp.com