Pacific Gas and Electric Company®

# Bargaining Unit Health Care 2006

ENROLLMENT GUIDE

## PG&E @ Work Benefits 2006

***Take Charge of Your Benefits!***

# Contents



*Take Charge of Your Benefits*

**SUMMARY OF MATERIAL MODIFICATIONS** *(October 2005)*

This guide is an overview of your Open Enrollment-related benefits. Complete details regarding benefit coverage are in the plan documents, contracts, and administrative policies available through the HR Service Center or through individual plan providers. Please note that this information does not replace all the documents governing the benefit plans, which will govern in case of any inconsistency. The Plan Administrator of each plan has the discretionary authority to interpret the provisions of the applicable plan. Since future conditions affecting the Company cannot be foreseen, Pacific Gas & Electric Company reserves the right to amend, modify, or terminate the benefit 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 *Bargaining Unit Employees*

## On behalf of PG&E, I'm pleased to welcome you to Open Enrollment 2006.

This year's benefits enrollment period kicks off as PG&E celebrates its 100-year anniversary. While we celebrate the company's history, we are also looking forward to the future and positioning PG&E for the next 100 years.

The company offers a comprehensive benefits packet, but it's up to you to take an active role in understanding your benefits and making choices that maximize the value for your personal situation.

This enrollment guide offers tips on how you can save money on your health care-related expenses and provides detailed information about the 2006 enrollment process and plan changes. We're offering a new medical plan administrator aimed at increasing service levels and lowering premium cost increases. Also new this year is our personalized enrollment gateway that provides step-by-step, online enrollment. I strongly encourage those of you who typically enroll online to continue to do so through this new tool.

You have important decisions to make and a variety of options from which to choose. And we're here to help. If you have any questions about your benefit plan options or how they work, please feel free to contact PG&E's HR Service Center at hrbenefitsquestions@pge.com, or by calling company extension 8-223-2363, 415-973-2363 or 800-788-2363.

Sincerely,

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

# Introduction

## 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 medical care facility mergers. Experts predict that the average cost increase to employers will be 11 to 14 percent for health care coverage in 2006.

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

## PG&E Makes Cost-Saving Changes

In addition to giving you a variety of medical plan options from which to choose, PG&E is implementing two significant changes that will help you manage your medical costs. The first change affects both employees and retirees; the second change will benefit you when you retire and/or become eligible for Medicare.

First, the company is switching the administration of the self-funded medical plans (NAP and CAP) from UnitedHealthcare to Blue Cross of California. This change will result in lower premium increases for these two plans in 2006. In addition, PG&E is passing along all of the company's net Medicare Part D saving to its Medicare members in the form of lower premium contributions.

Be sure to read about these changes and others in the "What's New for 2006" section of this guide.

## Take Charge of Your Health Care Decisions

While PG&E is working hard to help keep your health care costs as low as possible, the company needs your help. One of the most important things that you can do to maximize the value of your health care benefits — and the dollars you spend on related services — is to take an active role in making smart 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 each year to make sure you are selecting the best option.

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 2006?**

Consider deductibles and copayments for:

- primary care doctor, specialist, inpatient and outpatient 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 Blue Cross-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, so PG&E provides you with two ways to save. The Health Care and Dependent Care Reimbursement Accounts 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 21 and 22 of this guide.

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

If your medications are not covered by the plan, 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 for each plan I'm considering?

The monthly premium contributions for each plan available to you are shown on your 2006 Enrollment Worksheet. HMO premiums are generally less expensive than those for the Blue Cross-administered plans (formerly administered by UnitedHealthcare), so your portion of the cost for these plans will generally be less, too. Therefore, if your doctors participate in an HMO plan, 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 or visit its Web site to find out if your doctor is a participating physician (see outside back cover for plan contacts).

### What resources are available to me?

Each plan offers a variety of disease management programs and wellness services, such as nurse help-lines, surgery decision tools, nutrition guides, personal health records, health risk assessment tools and other features. Be sure to visit each health plan's Web site to see what is offered.

In addition, the Comparison of Benefits charts found in this guide show what the various medical plans cover for different 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 "Hot Tips" featured throughout this guide. They provide important bits of advice that can help you reduce your health care expenses, improve your health or simply get the most out of your medical plan.

# Open Enrollment 2006

This year's Open Enrollment period begins on **Friday, October 28, 2005, and ends on Thursday, November 10, 2005.** During this time, you'll have the opportunity to make changes to your medical, dental and vision coverage, as well as enroll in the reimbursement accounts for 2006, to ensure you have the best options for your individual needs. This guide provides you with updates on plan changes for 2006, as well as comprehensive information aimed at helping you maximize the value of your PG&E-sponsored benefits.

If you have a LAN ID and computer access at work, you can enroll online via the link you'll receive by email on October 28. Otherwise, you need to use the automated phone enrollment system.



### 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 2006, 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 9. Be sure to review the following:

- Your current medical plan's availability and monthly pre-tax cost for 2006, as shown on your Enrollment Worksheet
- Your dependents' eligibility (see pages 14 and 15)
- "What's New for 2006" (see pages 5-7) **and**
- Plan changes (indicated in bold on the Comparison of Benefits charts that begin on page 23).

Taking these easy steps will help you decide whether your current health care coverage, or different coverage, is best for you.

**IMPORTANT**

Open Enrollment begins on **Friday, October 28, 2005,** and ends on **Thursday, November 10, 2005.**

# What's NEW for 2006

## Notice of Creditable Coverage (NOCC)

The Notice of Creditable Coverage (NOCC), enclosed in your enrollment packet, is intended for members who are eligible or will be eligible for Medicare in 2006. The NOCC attests that the prescription drug coverage provided by PG&E's medical plans is at least as good as, or better than, the new Medicare Part D basic benefit. It also contains information that may be important to members on Medicare, or members who will become eligible for Medicare in 2006.

If you or your dependents will be eligible for Medicare in 2006, you should retain the NOCC for your records. If not, this document won't apply to you.

## Blue Cross Replaces UnitedHealthcare

As recently announced in various PG&E communications, Blue Cross of California will be replacing UnitedHealthcare as the plan administrator for PG&E's self-funded medical plans — including the Network Access Plan (NAP) and the Comprehensive Access Plan (CAP).

### Why PG&E Is Making the Change

Lower costs and better service — that's what PG&E believes will result by changing to Blue Cross of California. While this doesn't mean the rates will be lower than last year, it does mean that the 2006 rate increases will be smaller. In addition, Blue Cross has a track record of providing great service. For PG&E members this should translate to faster and more accurate claims processing and better overall customer service. Blue Cross members also benefit by having access to one of the largest provider networks in California. In fact, more than 95 percent of providers in the UnitedHealthcare network are also in the Blue Cross network. So, it's very likely that your current physicians are in the new network. What's more, many providers not currently available through UnitedHealthcare may now be available through Blue Cross.

The company's three employee unions have reviewed the selection of Blue Cross and support this change. Given Blue Cross of California's reputation for quality and customer service, this should be a positive change for both employees and the company.

### Plan Benefits to Remain the Same

The change to Blue Cross of California should not significantly affect the majority of employees currently enrolled in the UnitedHealthcare plans. All of the existing covered services, copayments, coinsurance and deductibles for the NAP and CAP plans will remain the same. None of the plan provisions are changing. In addition, the plan administrators for mental health/substance abuse benefits and prescription drug benefits will continue to be ValueOptions for the mental health/substance abuse program and Medco Health for prescription drugs.

### Largest Provider Network in California

Blue Cross' California network includes more than 45,000 physicians and 400-plus hospitals participating in its PPO (Prudent Buyer) network. For members who live or travel outside of California, the "BlueCard" program is available, providing nationwide access to all of the Blue Cross/Blue Shield PPO networks of doctors and hospitals (except the Blue Shield of California network).

**IMPORTANT**

The new Blue Cross-administered plans should not be confused with the Blue Shield HMO plan, which PG&E introduced to its members beginning in 2005. They are separate and distinct medical plan options.

To find out if your doctors are part of the Blue Cross PPO (Prudent Buyer) or BlueCard networks, review Blue Cross' provider directories at http://www.bluecrossca.com/clients/pge, or call Blue Cross at 800-964-0530. If, by chance, your physicians are not included in either of the networks, you do not necessarily have to change doctors. Instead, you can do one of the following:

1. Nominate your doctor(s) for participation in either network by completing the appropriate provider nomination form (PPO Network Provider Nomination Form or BlueCard Provider Nomination Form). Both forms can be obtained on Blue Cross' Web site, or by calling Blue Cross. Please keep in mind that the nomination/application process usually takes about four to six months, and it cannot be guaranteed that a contracting arrangement between your doctor and Blue Cross will result.

- or -

2. Continue to see your current doctor. If you are enrolled in the Network Access Plan (NAP), eligible expenses will be covered at a lower reimbursement rate under the NAP Non-Network benefit provisions. As always, members of the Comprehensive Access Plan (CAP) can use any doctor they want, although members may be "balance-billed" for charges above those that are considered "reasonable and customary" when seeing non-network doctors.



In early 2006, Blue Cross will send its PG&E members a welcome package with important information about claims procedures, medical management and disease management services.

### What You Need to Do

If you're currently enrolled in a UnitedHealthcare-administered plan (NAP or CAP), you will automatically remain in the same plan — to be administered by Blue Cross — in 2006, unless you select a different plan during the Open Enrollment period. You will receive a new Blue Cross identification card in early January.

If you don't want to stay in your current plan and if PG&E offers other medical plans in your area (as determined by your home ZIP code), you must actively enroll during Open Enrollment to select a different plan.

### Transition of Care Benefits

Blue Cross has a "Transition Assistance Program" that will allow for continuity of care for UnitedHealthcare members who have ongoing treatment needs at the time of the switch to Blue Cross. If you or any eligible dependents are pregnant or undergoing an active course of treatment for an acute or serious chronic condition that will extend beyond January 1, 2006, you may qualify for transition assistance. Applications for this program will be available December 1, 2005, and can be obtained by calling Blue Cross customer service or via Blue Cross' custom PG&E Web site. As administrator, Blue Cross will make all determinations of eligibility for this program.

### For More Information on Blue Cross

- Visit Blue Cross' custom Web site for PG&E members at www.bluecrossca.com/clients/pge.
- Call Blue Cross' new toll-free number, reserved exclusively for PG&E members, at 800-964-0530.
- Visit PG&E's Benefits Web site at wwwhr/Benefits.

### New Administrator for Flexible Spending Accounts (HCRA and DCRA)

Effective January 1, 2006, Ceridian will replace UnitedHealthcare as plan administrator for the Flexible Spending Accounts — the Health Care Reimbursement Account (HCRA) and the Dependent Care Reimbursement Account (DCRA).

Ceridian will continue to offer direct deposit as well as automatic reimbursement of out-of-pocket expenditures for Blue Cross and Medco prescription claims. In addition, dental and vision out-of-pocket expenses will be eligible for the automatic reimbursement feature.

Employees who enroll in an HCRA or DCRA during Open Enrollment will receive confirmation letters from Ceridian in early January 2006. The Web site for new participants will be available on January 1, 2006.

## HMO Changes

### PacifiCare Acquired by UnitedHealthcare

You may have heard that UnitedHealthcare is purchasing the PacifiCare HMO. PG&E has been informed that there will not be any operational changes to PacifiCare for 2006 as a result of UnitedHealthcare's acquisition, and that the HMO's network and benefits will continue with uninterrupted service. For additional information about PacifiCare, please call the HMO directly at the telephone number listed on the outside back cover of this guide.

### Other HMO Changes

Some of the HMOs are making changes to their service territories and primary care provider networks in 2006. The information provided in this guide is current as of October 2005. 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.

## HIPAA Special Enrollment Rights for Mid-Year Changes

Effective January 1, 2006, if you get married or have a baby or newly adopted child, or if your spouse or another dependent loses health care coverage, you may enroll yourself and any eligible dependents in PG&E's health care plans. If you are already enrolled in a PG&E-sponsored medical plan, you will not only be able to add eligible dependents, but you will also be able to change medical plans mid-year if you experience one of these specific events. For more information about making mid-year changes, please refer to Change-in-Status Events on page 16.

## PG&E Domestic Partnership Registry Changes

Effective August 1, 2005, PG&E closed its internal domestic partner registry. If your partnership is currently registered with PG&E, you will need to re-register with an outside municipality and then contact the HR Service Center to let the company know that you have appropriately registered your partnership. If you fail to to do so before the end of the year, your domestic partner benefits coverage will be terminated effective January 1, 2006. For a list of municipalities that currently offer a domestic partner registry, please visit the company's HR intranet site at wwwhr/benefits/DomesticPartner/DPpage.htm, or contact the HR Service Center to request a listing.

HOT 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.

# What You Need to Do for
## OPEN ENROLLMENT

## Five Easy Steps

**1** **Review your personalized 2006 Enrollment Worksheet.** The worksheet shows the plan options available to you for next year and your monthly pre-tax cost for each option.

**2** **Review your dependents' eligibility** (see pages 14 and 15 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 to request a "Notice of a COBRA Qualifying Event Notification." This form must be completed and returned to the HR Service Center within 60 days of the date on which your dependent loses coverage.

**3** **Review the information in this Enrollment Guide,** including the "What's New for 2006" section and Comparison of Benefits Charts. **If you are on Long-Term Disability and eligible for Medicare,** make sure you also read the *Understanding Medicare Part D and Your Medical Plan Options* booklet included in your enrollment packet.

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

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

- make plan changes — e.g., if your current medical plan is no longer available in your area and you do not want to be automatically switched to the Blue Cross-administered 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 2006. Remember, any current HCRA or DCRA elections you have will not be carried over automatically into 2006, so think carefully before passing up these valuable benefits.

See **Before You Enroll** on page 11 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 2006 and you want to be automatically switched to the Blue Cross-administered 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 2006.

If you don't enroll, you will receive the Default Coverage described on page 9.

**5** To enroll, use PG&E's automated phone system or the new online enrollment system. Please note that employees on Long-Term Disability must speak with a Benefits representative to make changes. See page 9 for details on how to enroll.

Within 10 days, you will receive a confirmation statement verifying your choices, which will be effective January 1, 2006.

See **"After You Enroll"** on page 12 for additional information.

**IMPORTANT**

If you are on Long-Term Disability and eligible for Medicare, make sure you also read the *Understanding Medicare Part D* booklet included in your enrollment packet.

### Default Coverage

- Your current 2005 medical coverage*, if your plan is still available in 2006 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 Blue Cross plan (NAP or CAP) available in your area, based upon your home ZIP Code.
- Your current 2005 dental coverage*
- Your current 2005 vision coverage*
- No reimbursement account contributions

** For you and your covered dependents, as listed on your 2006 Enrollment Worksheet.*

**HOT Tip**

You can't participate in the Reimbursement Accounts for 2006 (HCRA and DCRA) unless you enroll, so think carefully before passing up on these valuable benefits!

## How to Enroll

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

### Automated Phone System Enrollment

**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 a 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. to 5:30 p.m. during the Open Enrollment period. Employees on Long-Term Disability must speak with a representative to make changes.

Please use the company extension whenever possible. The "415" and "800" numbers are intended for employees to use only when a company line 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).

- or -

### Online Enrollment

If you have a PG&E LAN ID and computer access, you can enroll online using the link that will be emailed to you on October 28. The online enrollment system is available 24 hours every day on any company computer or from home using your PG&E Citrix account.

Please note: If you enroll online, your Benefits Confirmation Statement will be emailed to you.

**HOT Tip**

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.**

## IMPORTANT

Any changes you make during Open Enrollment will be effective January 1, 2006. Changes cannot be made after the Open Enrollment period ends on Thursday, November 10, 2005.

## YOUR AUTHORIZATION — PLEASE READ!

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

- acknowledge that you are responsible for reading the 2006 Enrollment Guide and reviewing your Confirmation Statement
- acknowledge that you have received the Notice of Creditable Coverage included in your Open Enrollment packet
- authorize the company to release Social Security numbers for you and your dependents 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 during 2006, even if your desired physician, hospital, medical group, or Independent Physician Association (IPA) does not participate in or terminates its relationship with your medical plan's network
- acknowledge that your current HCRA/DCRA elections cannot automatically roll forward into 2006 and that you must actively re-enroll to make new HCRA/DCRA elections for 2006
- 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
- agree to follow the appeal process for your plan for any disputed benefit claims **and**
- agree to call the HR Service Center to report any ineligible dependents within 31 days of a dependent's loss of eligibility.



## IMPORTANT

Enroll online or over the HR Service Center's automated phone system between Friday, October 28th and Thursday, November 10th.

# Before
## YOU ENROLL

### Considering Changing Medical Plans?

In most cases, you'll want to 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'll probably want to 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, such as chiropractic services or urgent care visits.

### Selecting Primary Care Physicians

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, 2006. Each plan has its own policy and timeframe for changing primary care physicians retroactively.

For a directory of PCPs, call the member services number of the medical plan you're considering, or visit its Web site. Phone numbers and Web site addresses for the medical plans are listed on the outside back cover of this guide.

### 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 a governmental agency that maintains a domestic partner registry. PG&E no longer maintains an internal registry, as described under "What's New for 2006" on page 7. 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 PG&E's HR intranet (from the PG&E @Work Today home page, select Human Resources/Benefits/Domestic Partnerships).

**IMPORTANT**

During Open Enrollment, if you are adding a newborn or adopted child to your health coverage for the upcoming year make sure you also add the child to your health plans for the **current** year. You'll need to call the HR Service Center **within 60 days of the child's birth or adoption** to do this. If you don't, your child's coverage will not be effective until January 1, 2006. See pages 16 and 17 for more information.

# 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 pages 16 and 17 for detailed information)
- You move out of your HMO's service territory **or**
- You retire.

**PLEASE NOTE!** If any of your primary care physicians, specialists, medical groups, Independent Practice Associations (IPAs), hospitals, or other providers withdraw from your medical plan during the year, you will not be able to change medical plans mid-year. Instead, you will need to obtain services from a new provider within your plan's network for the remainder of the year. The withdrawal of a provider from your plan is not an eligible change-in-status event.

## Confirmation Statements

**IBEW and SEIU Employees:**

- If you enroll online, you will receive your confirmation statement by email 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, 2005, verifying your coverage for 2006.

**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 company extension 8-223-2363, 415-973-2363 or 800-788-2363.

**ESC Employees:**

- No matter which way you enroll (online or over the phone), you will receive your confirmation statement by email within 10 working days.
- If you don't make any changes during Open Enrollment, you will receive a confirmation statement via email by December 31, 2005, verifying your coverage for 2006.
- 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 2006. In addition, all members enrolled in a Blue Cross-administered plan for 2006 will receive a new medical plan ID card.

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 Blue Cross plans also have the option of printing a copy of their ID cards off of Blue Cross' custom Web site for PG&E members at www.bluecrossca.com/clients/pge.

# 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.

### Find Valuable Information About Your Benefits On the Internet

Take advantage of our benefit plan providers' Internet sites to access information about your personal benefit plans. Plan Web site addresses are listed on the outside back cover of this booklet.

Some Web sites 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.

### Employee Assistance Program (EAP)

PG&E's Employee Assistance Program (EAP) is another valuable company-sponsored benefit provided at no charge to you and your family members. The EAP is available 24 hours per day, is completely confidential and offers counseling, education and referral services to help you address a wide array of personal and work/life issues, including the following:

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

Contact the EAP at 888-445-4436, or visit www.achievesolutions.net/pge.

# 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 refer to your *Summary of Benefits Handbook*.

## Eligible Dependents

Eligible dependents include:

- Your legally married spouse or registered domestic partner (see page 7 for updated information on the registry process for domestic partnerships)
- Your unmarried, dependent children who are under age 19, including step-children, children born during a domestic partner union, 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).

## 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. Call the HR Service Center at company extension 8-223-2363, 415-973-2363 or 800-788-2363 to drop any ineligible dependents.

## Domestic Partner Tax Certification

If your enrolled domestic partner and/or his or her enrolled child(ren) are tax dependents, 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. Forms received after the end of the year will not be processed for 2006.

## 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 to reflect the coverage of the child, if applicable.

**Domestic Partner Dependents**

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

## 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 a valid registry, or a former domestic partner (see page 7 for updated information on the registry process for domestic partnerships)

- Parents, step-parents, parents-in-law, grandparents and step-grandparents
- Former step-children or your step-children from a former domestic partner, unless they were born or adopted during the course of the domestic partnership, or you have been appointed permanent legal guardianship for them by a court
- Children age 19 through 23 who do not meet the current IRS definition of an eligible dependent
- Children age 24 and 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 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 for them by a court **or**
- A family member or domestic partner who is a PG&E utility or PG&E Corporation employee/retiree who has his or her own health coverage through PG&E or is eligible for Flex Benefits.



## IMPORTANT

**There are Penalties for Covering Ineligible Dependents!**

Remember, it is your responsibility to be sure all the dependents you enroll for coverage are eligible. Dependents who lose eligibility during the year must be dropped within 31 days of the dependent's loss of eligibility. 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.

To drop ineligible dependents, call the HR Service Center at company extension 8-223-2363, 415-973-2363 or 800-788-2363.

# Change-in-Status EVENTS

## What's a Change-in-Status Event?

A change-in-status event is a life event that allows for changes in benefits elections after the plan year has begun. Only certain changes in status are permitted, due to restrictions imposed by federal registration governing the administration of pre-tax benefit plans like those offered at PG&E (see page 17 for eligible 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.

Any changes that you request typically must be consistent with a change-in-status event. For example, if a dependent child regains eligibility, you may add the child to your coverage; however, you cannot change plans. Accordingly, if you move out of your HMO's service territory, you may change plans, but you cannot add new dependents. The only exception is when you experience one of the events that trigger the new HIPAA Special Enrollment Rights, as described on page 7. Effective January 1, 2006, if you get married or have a newborn or newly adopted child, or if your spouse or another dependent loses health care coverage, you may enroll yourself and any eligible dependents in PG&E's health care plans, and you may also change medical plans.

**PLEASE NOTE!** The withdrawal of a provider, e.g., a doctor, medical group, hospital, etc., from your plan's network — or the fact that you want to use a particular provider who is not part of the network — is not an eligible change-in-status event. If any of your providers withdraw from or do not contract with your medical plan's network, you must obtain services from a different provider within your plan's network for the rest of the year. You cannot change medical plans during the year if your desired provider does not contract with your plan.



## IMPORTANT

Call the HR Service Center within 31 days of any eligible change-in-status event (60 days for births and adoptions) 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.

**HR Service Center**

**Company extension 8-223-2363, 415-973-2363 or 800-788-2363**

## Eligible Change-in-Status Events

Qualifying change-in-status events include the following:

- 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 health plan coverage
- 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. If you don't, medical services you receive may not be covered. For more details, refer to your *Summary of Benefits Handbook*.

### Important Information About Adding Newborn or Adopted Children

To ensure that your child has continuous health coverage from birth or adoption, you must **call the HR Service Center within 60 days of your child's birth or adoption** to add the child to your health plan(s). If you don't call within 60 days, your child's coverage will be cancelled and you won't be able to add the child until the next Open Enrollment period. Please note that if you add your child during Open Enrollment only, the child's coverage will not be effective until January and you may have a gap in coverage. In all cases, please call the HR Service Center promptly to add newborn or newly adopted children.

# 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 notify the company within 60 days of losing coverage and submit a "Notice of Qualifying Event" form to the HR Service Center.

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* or your *2005 Summary of Material Modifications*.

## 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 timeframe. 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 network of dentists, call Delta Dental at 888-217-5323, or check its Web site at www.deltadentalca.org.

## Delta Dental Benefits

| Provision | 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*

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



**IMPORTANT**

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

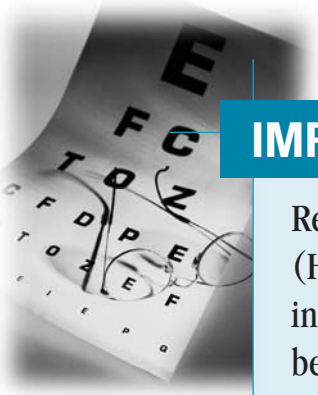
## COVERAGE

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 Web site 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<br>$25 materials (lenses and frames)* |
| **Plan benefits with VSP doctor** | ■ **Vision Exams** – Every 12 months<br>■ **Eyeglass Lenses** – Every 12 months<br>■ **Frames** – Every 24 months<br>■ **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<br>● **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<br>● **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

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. As described under "What's New for 2006," both accounts will be administered by Ceridian effective January 1, 2006.

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 pay the provider and then file a claim for reimbursement from your account — which reimburses you with pre-tax dollars. Reimbursement checks will be mailed to your home, or you may elect the convenient option of having your reimbursement checks directly deposited to the banking institution of your choice. An added feature for HCRA participants is the "Automatic Reimbursement" option which allows you to have your out-of-pocket medical, dental, vision and/or prescription drug expenses (copayments, coinsurance, deductibles, etc.) automatically forwarded to Ceridian for reimbursement, thereby eliminating the need to submit claim forms for many health care expenses.

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 2006, you must enroll during Open Enrollment to indicate the **annual** amount you want to contribute.

**IMPORTANT**

Your HCRA/DCRA elections for 2005 cannot be carried over automatically into 2006.



### How Much Can You Contribute Each Year?

| Reimbursement Account | Annual Contribution Amount |
|---|---|
| **Health Care** | $5,000 maximum per individual |
| **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)<br><br>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. |

## 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 Web site at www.irs.gov. In addition, although the IRS does not allow over-the-counter (OTC) drug expenses for tax deduction purposes, some OTC drugs may be eligible for reimbursement through the HCRA. Please call Ceridian at 877-799-8820 or check PG&E's HR intranet site 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, ***unless*** such change in cost is triggered by a valid change-in-status event.

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

## 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 Web site 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.

HOT *Tip*

Although the IRS does not allow over-the-counter (OTC) drug expenses for tax deduction purposes, some OTC drugs may be eligible for reimbursement through the HCRA.

# Comparison of Prescription Drug Benefits

## FOR THE NAP AND CAP PLANS
## (DRUG BENEFITS ADMINISTERED BY MEDCO HEALTH)

The following table summarizes the prescription drug benefits for members enrolled in the Blue Cross-administered plans. Plan benefits are administered by Medco Health. Please note that the Medco Health out-of-pocket maximum must be met separately from the Blue Cross out-of-pocket maximum. Also, some drugs may not be covered or may require special authorization from your plan. For specific information about a plan's prescription drug coverage, call the plan's member services department directly, or visit its Web site at the Internet address listed on the outside back cover.

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 Web site at the Internet address listed on the outside back cover.

Some drugs may not be covered or may require special authorization from your plan. For specific information about a plan's prescription drug coverage, call the plan's member services department directly, or visit its Web site 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)<br><br>Refills beyond 90 days and coverage at non-participating pharmacies: 80% for generics and 70% for brand names; Generic Incentive Provision applies (see below) |
| **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) |
| **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 mail-order 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 mail-order plans, 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 HMO | Health Net HMO |
|---|---|---|
| **General** | Members access the Blue Shield HMO network; no pre-existing condition exclusions | Only providers affiliated with Health Net HMO; no pre-existing condition exclusions |
| **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<br>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** | Included in office visit; no charge for allergy injections if no visit with physician | Included in office visit; no charge for allergy injections if no visit with physician |
| **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; provided 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 (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 (through the plan): two times retail copay for up to a 90-day supply; no annual maximum; open formulary | RETAIL (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 (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 require; 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 2006 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 North HMO | Kaiser South HMO |
|---|---|---|
| **General** | Services provided at Kaiser Permanente Hospitals and Offices by Kaiser Permanente doctors; no pre-existing condition exclusions | Services provided at Kaiser Permanente Hospitals and Offices by Kaiser Permanente doctors; no pre-existing condition exclusions |
| **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<br>Home visit – No charge | Office visit – $10<br>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 2006 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 HMO |
|---|---|
| **General** | Only providers affiliated with PacifiCare HMO; no pre-existing condition exclusions |
| **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<br>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<br>$50 copay for 30-day supply of self-injectable medication |
| **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 diagnosis): 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;<br>$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*

*Changes for 2006 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 | Comprehensive Access Plan (CAP)<br>Administered by Blue Cross |
|---|---|
| **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; no pre-existing condition exclusions<br>*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; Excludes custodial care |
| **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 required for delivery stays beyond 48 hours for normal delivery or 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; excludes custodial care |
| **Hospice Care** | 90%; requires prior authorization; $300 penalty if not obtained; excludes custodial care |
| **Outpatient Physical Therapy** | 80% |
| **Outpatient Prescription Drugs** | Covered by separate drug plan administered by Medco Health; see page 23 for details |
| **Mental Health** | Covered by separate Mental Health Program |
| Inpatient Care | ■ 100% with referral by ValueOptions; 50% without referral |
| Outpatient Care | ■ $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 |

** "Eligible Expenses" are: (1) expenses for Covered Health Services that are covered by the plan; (2) those that Blue Cross 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 Blue Cross of California. Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Blue Cross Member Services.*

*Changes for 2006 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 Blue Cross | |
|---|---|---|
| | **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; no pre-existing condition exclusions | 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; no pre-existing condition exclusions<br>*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; excludes custodial care | 70% for semi-private room after 3 days in hospital; preauthorization required, $300 penalty if not obtained; excludes custodial care |
| **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 required for delivery stays beyond 48 hours for normal delivery or 96 hours for cesarean section; $300 penalty if not obtained | Covered as any other condition; preauthorization required for delivery stays beyond 48 hours for normal delivery or 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; excludes custodial care | 70%; requires prior authorization; $300 penalty if not obtained; excludes custodial care |
| **Hospice Care** | 90%; requires prior authorization; $300 penalty if not obtained; excludes custodial care | 70%; requires prior authorization; $300 penalty if not obtained; excludes custodial care |
| **Outpatient Physical Therapy** | 80% | 70% |
| **Outpatient Prescription Drugs** | Covered by separate drug plan administered by Medco Health; see page 23 for details | Covered by separate drug plan administered by Medco Health see page 23 for details |
| **Mental Health** | Covered by separate Mental Health Program | Covered by separate Mental Health Program |
| Inpatient Care | ■ 100% with referral by ValueOptions; 50% without referral | ■ 100% with referral by ValueOptions; 50% without referral |
| Outpatient Care | ■ $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 | ■ $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 | Infertility – Paid according to type of benefit; $7,000 lifetime maximum; balances from prior plans carry forward |

** "Eligible Expenses" are: (1) expenses for Covered Health Services that are covered by the plan; (2) those that Blue Cross 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 Blue Cross of California. Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Blue Cross Member Services.*

*Changes for 2006 are in bold-faced type*

# 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 HMO | Health Net HMO | Kaiser North & South HMO | PacifiCare HMO |
|---|---|---|---|---|
| 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 | | | ▲ | |

Pacific Gas and Electric Company®

# Where to Get Help

| Contact | Email | Web Site | Phone Number |
|---|---|---|---|
| **PG&E HR Service Center** | HRBenefitsQuestions@pge.com | wwwhr | Company ext. 8-223-2363, 415-973-2363 or 800-788-2363 |
| **IRS (IRS Publications)** | | www.irs.gov | 800-829-3676 |
| PG&E's ***Summary of Benefits Handbook*** | | | |

# Member Services Contacts

| Plan | Phone Number | Web Site |
|---|---|---|
| **Blue Shield HMO** | 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 HMO** | 800-522-0088 | www.healthnet.com |
| **Kaiser (North and South) HMO** | 800-464-4000 | my.kaiserpermanente.org/ca/pge |
| **PacifiCare HMO** | 800-624-8822 | www.pacificare.com |
| **PG&E Medical Plans** (Administered by Blue Cross of California) | 800-964-0530 | www.bluecrossca.com *or* www.bluecrossca.com/clients/pge |
| Network Access Plan (NAP) | | |
| Comprehensive Access Plan (CAP) | | |
| American Specialty Health Network | 800-678-9133 | www.ashcompanies.com |
| **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 Ceridian) | 877-799-8820 | www.ceridian-benefits.com |
| **Vision Plan** (Administered by Vision Service Plan) | 800-877-7195 | www.vsp.com |