Live Bright

2009 Benefits Enrollment Guide for Employees Represented by the IBEW, ESC and SEIU

Take advantage of the health and wellness resources available to you and your family—and live bright. PG&E offers an outstanding benefits package designed to promote and support employee health and wellness. Your benefits options are explained in this guide and the Supplement to Your 2009 Benefits Enrollment Guide. Take the time to review these materials, understand your options and make the best decisions for your situation.

This Benefits Enrollment Guide for Employees Represented by the IBEW, ESC and SEIU and the Supplement to Your 2009 Benefits Enrollment Guide (referred to collectively as the "Enrollment Guide") is designed, in part, to make you aware of important changes which have been made to The Pacific Gas and Electric Company Health Care Plan for Active Employees and The Pacific Gas and Electric Company Health Care Reimbursement Account Plan (collectively, "The Plans"). The Enrollment Guide is not an exhaustive explanation of the Health Care Plan. Additional information about the Plans is contained in the documents entitled The Pacific Gas and Electric Company Health Care Plan for Active Employees, the Summary of Benefits Handbook and the Summaries of Material Modifications (SMMs) including enrollment guides designated as SMMs, as well as the Evidence of Coverage booklets issued by HMOs and the Anthem Blue Cross SmartValue Plan, which collectively constitute the official plan document.

The Employee Benefits Committee of PG&E Corporation is the Plan Administrator of The Plans and has the discretionary authority to interpret and construe the terms of the official plan document, to resolve any conflicts or discrepancies between the documents which comprise the official plan document and to establish rules which are necessary for the administration of The Plans.

Unless otherwise noted, references in this guide to PG&E mean Pacific Gas and Electric Company. Pacific Gas and Electric Company, PG&E Corporation and their affiliates are referred to collectively as "Participating Employers."

What's Inside

About this guide

This Benefits Enrollment Guide describes your benefit choices and your options to enroll. For information on eligibility, change-in-status events, COBRA and other legally required information, see the Supplement to Your 2009 Benefits Enrollment Guide. **If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, please see page 10 in the Supplement for important information about your prescription drug coverage and Medicare.**

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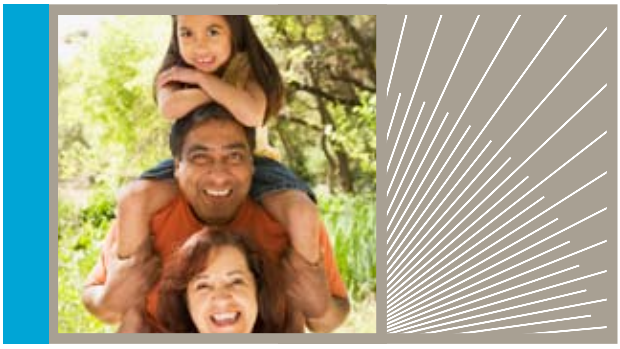


PG&E's benefits package offers you many ways to save money, and be healthy and energized so you can live bright. Living bright is all about taking advantage of available wellness tools and resources, making healthy lifestyle choices and being informed about health issues overall. And remember, taking care of yourself also helps ensure you stay safe on the job.

To make the most of your benefits, be sure to take advantage of...

- **Preventive care coverage:** All of our medical plan options cover exams and screenings at little or no cost to you. Be sure to get an annual physical including cholesterol and blood pressure screenings. And—depending on your age and gender—mammograms, prostate cancer screenings and colonoscopies are critical as well. Spending $10 now to check your blood pressure can save over $100,000 later on if you have a stroke, not to mention the impact on your quality of life.
- **Wellness support:** PG&E-sponsored medical plans provide an array of programs to help you manage your specific health care needs. Contact your medical plan or visit its Web site to learn more. (See pages 28 and 29 for contact information.)
  - *Nurse advice lines:* Have symptoms or a medical question? These 24-hour telephone advice lines let you discuss medical issues with a nurse.
  - *Focused health programs:* Have diabetes, heart disease or asthma? Do you smoke? These programs provide personalized, ongoing assistance with these issues.
  - *Decision support:* Facing surgery? Have you received conflicting second opinions? These programs offer nurses and coaches backed by powerful databases to help you make informed decisions.
  - *Online health assessments:* These assessments provide advice to help you improve your health. Already consider yourself healthy? Many are surprised by how much they can do to get even more fit.
  - *Discounts on fitness club memberships:* Take advantage of special discounts if offered through your medical plan.
- **Flexible Spending Accounts:** Why pass up the chance to save money on taxes? When you set aside before-tax dollars in these accounts to pay for health care and dependent care expenses, you lower your taxable income. See page 12 for details.
- **Employee Assistance Program (EAP)**: Getting healthy isn't just about exercise. It's also about emotional health. Available 24 hours a day, the EAP is a benefit provided by PG&E at no charge to you. Get confidential help with marital and family problems, alcohol and drug issues, anxiety, depression, workplace concerns, child/elder care issues and legal/financial concerns. Contact the EAP hotline toll-free at 1-888-445-4436, or visit the **Plans, Policies & Forms** section of the HR intranet or *www.achievesolutions.net/pge* for a list of onsite EAP counsellors.

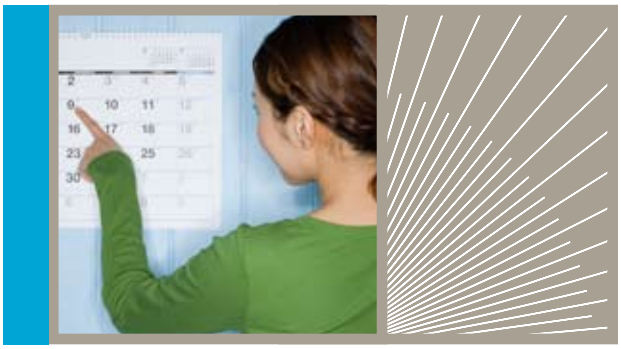
Enrollment: What You Need To Do

You will need to make choices about which PG&E benefits you'd like to participate in during "Enrollment Windows." Enrollment windows are specific times that will require you to take action and select your benefits:

- When you are hired as a PG&E employee (you have 31 calendar days to enroll). Elections you make generally become effective the first of the month following receipt of your elections.
- During the annual Open Enrollment period (two weeks each year in the fall). Any changes you make during the Open Enrollment period become effective January 1 of the following year.
- When you experience an eligible change-in-status event such as marriage or the birth of a child. You must report eligible change-in-status events to the HR Service Center within 31 days of the event (60 days for the birth or adoption of a child) in order to make any allowable changes to your benefits.

Each time an enrollment window occurs, use this guide to familiarize yourself with the most current information on PG&E's benefits programs and what coverage options are available to you. You can also use the information here to:

- Get ready to enroll
- Understand how you can enroll
- Know what to expect after you enroll.



Get Ready to Enroll

1. **Review your options, ask questions and talk with your family.** If you're thinking of changing medical plans or you are choosing for the first time:
   - **a.** Check with your doctors to find out which plans they participate in.
   - **b.** If you take any prescription medications regularly, contact the new plan to find out how these drugs are covered (for example, formulary or nonformulary drugs).
   - **c.** Review the coverage offered for specific types of services that you and your family tend to use regularly, such as chiropractic care or urgent care.

   To gather this information, call the medical plan's Member Services number or visit its Web site (shown on pages 28 and 29 of this guide, along with medical plan group numbers, if applicable).

2. **Consider not only your current circumstances, but what may be happening in your life in the future.** Outside of the two-week Open Enrollment period, you will not be able to make changes to your benefits elections unless:
   - **a.** You have an eligible change-in-status event or HIPAA special enrollment event (for example, you get married or have a child). HIPAA special enrollment events are explained in more detail on page 8 of the Supplement to Your 2009 Benefits Enrollment Guide
   - **b.** You move out of your HMO service area
   - **c.** You retire.

   See the section on page 6 for more information about reporting change-in-status events.

3. **Review your Enrollment Worksheet, showing your plan options and costs.** Many people make the mistake of choosing a plan based solely on the monthly premium. Think about which plan is the most cost-effective for you and best meets your health care needs at a total price you can afford. Here are some things to consider:

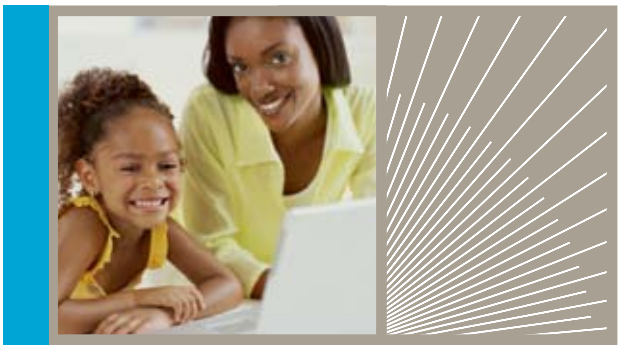
   a. **What the plans cover.** The comparison of benefits charts in this guide will help explain what each plan covers.

   b. **Your estimated usage.** Consider the services you use the most or will need in the future. Does your plan choice cover those services adequately?

   c. **Flexibility in choice of doctors, hospitals and how you receive care.** Each plan may include a different set of doctors or hospitals or have different rules for how to receive care.

   d. **Verify service areas and provider availability**, since all medical plans make ongoing changes during the year.

4. **Review the eligibility provisions** on page 5 of the Supplement to Your 2009 Benefits Enrollment Guide. If your dependent is losing health plan eligibility, you must contact the HR Service Center at 415-973-4357 or 1-800-788-2363 within 31 days of the dependent's loss of eligibility. The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows you or your covered dependents to continue participation in company-sponsored health plans beyond the normal period if coverage is lost due to a COBRA-qualifying event. See page 8 of the Supplement to Your 2009 Benefits Enrollment Guide for more information.



PG&E-sponsored medical plan vendors conduct an annual certification process for your enrolled dependents between the ages of 19 and 23. So, if you receive a letter from your medical plan vendor requesting dependent certification, you must complete the form and send it back to your plan as soon as possible. Otherwise, your child will be dropped from your health benefits and may not be reinstated until the next Open Enrollment period. For dependents who are disabled, you must contact the plan vendor directly to process the required certification before he or she turns 24. If you do not complete the certification on time, your disabled dependent can no longer be enrolled in the plan after the first of the month in which he or she turns 24.

You must drop ineligible dependents from coverage under PG&E-sponsored health plans within 31 days from the loss of eligibility. PG&E employees who cover ineligible dependents will be required to make restitution to the company for the associated costs of providing health care coverage, up to two full years of premiums or premium equivalents.

How to Enroll

During the annual Open Enrollment period:

- All employees represented by the IBEW, ESC and SEIU can enroll online through *PG&E@Work For Me* on the company intranet. Employees who are not chiefs (supervisors) or delegates can also enroll from any computer through *PG&E@Work For Me* on the Internet (*https://myportal.pge.com*). Chiefs and delegates can access *PG&E@Work For Me* from home via Citrix or VPN. Enrolling online offers several advantages—it's secure, it's easy and it's fast. By enrolling online, you can quickly access your benefit options and see your confirmation statement immediately after you've enrolled. More information about enrolling online is provided on the next page.
- Employees represented by the IBEW and SEIU can also enroll over the phone by calling the HR Service Center at 415-973-4357 or 1-800-788-2363.

- Employees on leave of absence or Workers' Compensation can make benefits elections over the phone by calling the HR Service Center. See the section *Special Guidelines* for *Employees on a Leave of Absence* on page 7 for more instructions.

When first hired:

- New employees enrolling in benefits for the first time must complete the benefits enrollment form included in your benefit enrollment kit and return it to the HR Service Center within 31 days from the first day of employment. Go to the **HR intranet > Plans, Policies & Forms > Job Changes > When You Start Work at PG&E** for more details.

When there is an eligible change-in-status event:

- Employees making benefit changes because of an eligible change-in-status event must make benefit changes over the phone by calling the HR Service Center. Go to the **HR intranet > Plans, Policies & Forms > Life Changes** or **Plans, Policies & Forms > Job Changes** section for more details.

ENROLLING ONLINE

To access *PG&E@Work For Me* on the company intranet (also applies to employees logging on through Citrix or VPN):

- Go to the HR intranet site at *www/HR/index.shtml*, or choose *PG&E@Work For Me* from the company intranet home page, under "My Stuff."
- Choose the Open Enrollment tab.

To access *PG&E@Work For Me* on the Internet from any computer with Internet Explorer (version 5.0, 6.0 and 7.0):

- Go to *https://myportal.pge.com*. If you're logging on for the first time, click the Help Guides link at the bottom of the page and follow the instructions to access the system.
- Choose the Open Enrollment tab.

Then, follow these steps:

Review your dependents	Make any necessary changes to your dependents. Have the following information on hand if you want to make changes: ◆ Full name, birth date, gender, Social Security number, relationship (for example, spouse, child, same-sex spouse or domestic partner) and Medicare claim number and effective date for any Medicare-eligible dependents (you can find this on the Medicare card). If you want to add a same-sex spouse/domestic partner and/or a same-sex spouse's/domestic partner's child(ren) to your plan, see page 5 of the Supplement to Your 2009 Benefits Enrollment Guide. If you want to remove a Medicare-eligible dependent, call the HR Service Center or send an e-mail to *hrbenefitsquestions@exchange.pge.com*.
Confirm your home address and phone number	If you regularly receive mail at a location other than your residence, you can add your mailing address from **About Me > My Contact Info** after you complete your benefits enrollment.
Select your benefit options (enroll)	Enroll in the benefit plan options available to you that best fit your needs and the needs of your family.
Review your confirmation statement	Verify the options you selected are shown on your confirmation statement. ◆ You can access your confirmation statement through *PG&E@Work For Me* at any time after you enroll. ◆ If you are on leave of absence or Workers' Compensation and you enroll by telephone, you'll receive a confirmation statement mailed to your home address of record. If you find an error, call the HR Service Center within 10 business days. All changes must be made in the current plan year. You cannot make changes based on your confirmation statement in the following plan year.
Print your confirmation statement	Keep a copy of your statement for future reference.

If You Don't Enroll

New full-time and part-time union-represented employees of Pacific Gas and Electric Company who do not enroll in health care benefits within 31 days of hire will not be eligible for coverage for the remainder of the year. You must wait until the next open enrollment period unless you experience a HIPAA special enrollment event.

If you are an active employee and you don't enroll during the Open Enrollment period, you will continue to receive your current year's medical, dental, vision and life insurance coverage for yourself and your covered dependents, as listed on your Enrollment Worksheet. If your current medical plan is being discontinued or will no longer be available in 2009, your worksheet will highlight the alternative medical plan into which you will be automatically enrolled if you do not follow the enrollment process explained in this guide. You will not participate in Flexible Spending Accounts.

Questions?

If you have questions about your benefit choices for 2009 or do not have Internet access, please call the HR Service Center at 415-973-4357 or 1-800-788-2363 for assistance. Representatives are available from 7:30 a.m. to 5:30 p.m. Pacific Time, Monday through Friday. Or, send your question via e-mail to ***hrbenefitsquestions@exchange.pge.com****. Please allow one business day for a response.*

Reporting Life Changes (change-in-status events)

If you experience an eligible change-in-status event (such as marriage or divorce), you have 31 days (60 days for the birth or adoption of a child) to make any allowable changes to your benefits. Otherwise, you may not be able to add dependents or change the amount you contribute to your HCRA or DCRA until the next Open Enrollment period. To add a new eligible dependent(s) to your health care coverage for the *current* plan year, please call the HR Service Center within 31 days (60 days for the birth or adoption of a child). You can make dependent changes or updates as necessary during the Open Enrollment period. See page 4 of the Supplement to Your 2009 Benefits Enrollment Guide for more details on eligible dependents.

Contact the HR Service Center to report any eligible change-in-status events or to ask questions about your benefits.

After You Enroll

Here's a quick look at what to expect after you enroll.

ID CARDS

If you change medical plans or add dependents, you'll receive your new medical plan identification card(s) within a few weeks if enrolling as a new employee, or in January of the following year if enrolling during the Open Enrollment period. If you don't receive your new ID card(s) as expected, call your medical plan directly. If you need to see a doctor before your ID card arrives, use your confirmation statement as proof of coverage. Members in the Anthem Blue Cross-administered plans and the Health Net HMO plans can print a copy of their ID cards from the plan's Web site.

SELECTING PRIMARY CARE PHYSICIANS

You are not required to select a primary care physician (PCP) if you enroll in the Network Access Plan (NAP) or Comprehensive Access Plan (CAP). However, all HMOs except Kaiser Permanente require that you and your covered dependents each select a PCP from the plan's network. When you first enroll in one of these plans, the HMO will automatically assign a PCP. To choose a different PCP, call your plan after you receive your ID card and request that your PCP selection be made retroactive to the new plan year if you are enrolling during the Open Enrollment period or to the date of eligibility if you are enrolling for the first time. Each plan has its own policy and timeframe for changing PCPs retroactively.

Special Guidelines for Employees on a Leave of Absence

If you are on a leave of absence, special enrollment guidelines apply to you. Read on for more information.

- **Flexible Spending Accounts:** You may elect to contribute to a Health Care Reimbursement Account (HCRA) for 2009. If you elect this option, you will receive a *Health Care Reimbursement Account Election While on a Leave of Absence* form soon after you enroll. You must complete this form and return it to the HR Service Center within 15 days of receipt. You may not elect to contribute to a Dependent Care Reimbursement Account (DCRA) for 2009 during Open Enrollment; however, you will have the opportunity to participate when you return to work.
- **Medical Plan Premiums:** The rates shown on your personalized 2009 Enrollment Worksheet reflect your portion of the regular medical plan premium for each available medical plan option. The rate will be deducted from your pay when you return to work or billed on a monthly basis, depending on the election you made when you began your leave. Whether you are a full-time or part-time employee, if you are on a medical leave that will continue into 2009 and you are being billed for your premiums, you will be billed the new rate as shown on your Enrollment Worksheet beginning January 1, 2009. If you are on a personal leave (including child care leave) and paying the full premium, or if you will start the fourth month of your leave in 2009, you will be responsible for paying the rate shown on your Enrollment Worksheet.

  If you elected to defer payment of your premium contributions while on leave, the 2009 premiums listed on your Enrollment Worksheet will be accrued beginning January 1, 2009. All deferred premium contributions will be deducted from your pay when you return to work, in addition to your regular premium contributions.

HOW YOUR LEAVE STATUS MAY AFFECT YOUR COVERAGE

If you return to work before the end of 2008:

- The 2008 elections you made before your leave, including your DCRA (but not including your HCRA), if applicable, will automatically resume the first of the month following your return to work.
- If you want to reinstate your participation in the HCRA because you did not continue HCRA during your leave, if applicable, you must call the HR Service Center within 31 days of your return to work. If you do not call within 31 days, you will not be enrolled in this account for the remainder of the year.
- Any elections you make during the annual Open Enrollment period will become effective January 1, 2009. If you do not make any changes during Open Enrollment, you will continue to be enrolled in the plans you were enrolled in prior to your leave (or the alternative medical plan indicated on your Enrollment Worksheet if your plan is no longer available), with the same dependents. However, you will not be able to participate in the Flexible Spending Accounts in 2009.

If you return to work in 2009:

- If you do not make changes during Open Enrollment, you will continue in the same medical coverage (or the alternative medical plan indicated on your Enrollment Worksheet if your plan is no longer available) with the same dependents, effective January 1, 2009.
- When you return to work, you will receive another enrollment packet. You can change your elections for the remainder of 2009. Coverage will take effect the first of the month following receipt of your elections, provided they are received by the HR Service Center within 31 days of your return to work. At that time, you may also add any eligible dependents acquired during your leave and enroll in the HCRA if you did not enroll for this account during Open Enrollment. You will also be able to enroll in the DCRA if your dependent care needs change because you returned to work.
- If you do not make elections for yourself and your dependents within 31 days of your return to work, you will have the same coverage you elected during Open Enrollment, or the alternative medical plan indicated on your Enrollment Worksheet if your plan is no longer available and you do not enroll during Open Enrollment. You will not be able to participate in the HCRA or DCRA.

Understanding Your Benefits

Medical

PG&E offers a variety of medical plan choices. See your Enrollment Worksheet to find out which of these plans are available to you and your costs for coverage:

- **Network Access Plan (NAP):** This Preferred Provider Organization (PPO) plan administered by Anthem Blue Cross gives you the flexibility to choose network or non-network providers. Your cost for services is less when you use network providers.
- **Comprehensive Access Plan (CAP):** This out-of-area plan, also administered by Anthem Blue Cross, is for employees who do not live in the NAP's service area. This plan lets you choose any provider.
- **Blue Shield, Health Net and Kaiser Permanente HMOs:** These plans cover most services in full, but you must use the HMO's network providers to receive coverage.

See the Comparison of Medical Benefits charts on pages 16 to 23 for medical coverage details.

ADVANTAGES TO MEMBERS

PG&E's medical programs are committed to creating a partnership with employees that promotes a healthy lifestyle. These programs are a part of our medical plans and are designed to provide you and your

family with programs and tools to more effectively understand and manage your health care needs. Contact your medical plan or visit its Web site to learn more. (See pages 28 and 29 for contact information.)

- **Nurse Advice Line:** Nurse Advice lines provide confidential, free medical advice to you 24 hours a day, 365 days a year.
- **Disease Management Programs:** Disease Management programs partner with your physician(s) to help you manage diseases such as asthma and diabetes.
- **Decision support:** Facing surgery? Have you received conflicting second opinions? These programs offer nurses and coaches backed by powerful databases to help you make informed decisions.
- **Discounts on fitness club memberships:** Take advantage of special discounts if offered through your medical plan.

Check Out Your Health Plan's Web Site

Use the provider Web sites (listed on pages 28 and 29) to:

- *Learn about health and wellness topics, such as fitness, nutrition and prenatal care*
- *Find out how your hospital or doctors rank in quality compared to their peers*
- *Confirm eligibility for yourself and your dependents*
- *Request new or replacement ID cards*
- *Check the status of your claims*
- *Search for providers and switch primary care physicians*
- *Get wellness discounts*
- *Check drug formulary information or order refills*
- *Download and print forms.*

Dental

You can save money on dental services by using a PPO dentist. When you need dental care, you choose which type of dentist to use under the Delta Dental Plan:

- **Delta Dental PPO dentist (not available to ESC-represented employees):** This option is the least expensive, since the deductible and costs of dental services are generally lower. If you use only Delta Dental PPO dentists throughout the full calendar year, you will pay a lower deductible.
- **Delta Dental Premier dentist:** This option provides the standard reimbursement. If at any time you use a Delta Dental Premier dentist who is only in the Premier network, the higher deductible will apply. The maximum total deductible you will pay in any calendar year is $50, since you will not be required to pay a separate deductible for using a PPO dentist.
- **Non-Delta Dental dentist:** This option is generally the most expensive.

Note that if you visit a non-Delta Dental dentist, you will generally be reimbursed at a much lower rate. On top of your deductible and the percentage you pay for covered charges, you will be required to pay the difference between the fees charged by your dentist and Delta's allowed rates (known as the "prevailing" fees, as determined by Delta), which are generally lower. If you visit a Delta Dental PPO or Premier dentist, you will not have to pay this difference.

If you need extensive dental work, such as a crown, root canal or bridge, ask your dentist (whether a Delta Dental dentist or not) to file a "predetermination," also called a "pretreatment estimate," before performing the services. Delta Dental will notify you and your dentist in writing as to whether the procedure is covered and, if so, provide an estimate of your cost.

For a list of Delta Dental PPO or Premier dentists, check Delta's Web site at *www.deltadentalca.org*.

DELTA DENTAL BENEFITS	
Provisions	***Dental 1***
Choice of dentist	Any; for maximum benefits, use a PPO or Premier Dentist
Annual deductible (PPO Dentist)	$25/individual and $75/family for all covered services other than preventive and diagnostic (available to IBEW-represented and SEIU-represented employees only)
Annual deductible (Premier Dentist)	$50/individual and $150/family for all covered services other than preventive and diagnostic
Diagnostic and preventive care	85% of eligible preventive care; includes two exams per year, full-mouth X-rays once every five years, bitewing X-rays twice per year for dependents up to age 18 and once per year for adults age 18 and over, two cleanings per year, fluoride treatments and space maintainers
Basic care	85% of eligible basic care; includes fillings, root canals, extractions, oral surgery and treatment of the gums (periodontia); also includes sealants for eligible dependents under 16
Major care	85% of eligible major care; includes crowns, jackets, inlays, onlays, cast restorations and bridges
Annual maximum benefit	$2,000 per individual (excludes orthodontia)
Orthodontia	50% up to a $1,500/individual lifetime benefit

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

Vision

With the Vision Service Plan (VSP), you can use any vision provider you choose. Generally, you'll pay less when you use a VSP provider. If you use a non-VSP provider, you must pay your bill in full, and VSP will reimburse you based on a schedule of benefits.

VISION CARE BENEFITS	
Choice of doctor	Any; for maximum benefits, use a VSP member doctor
Copayments with VSP doctor (apply 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; once you obtain frames, you are not eligible for frames again for 24 months ◆ Contact Lenses, Elective and Visually Necessary—Every 12 months instead of all other lens and frame benefits; once you obtain contact lenses, you are not eligible for lenses again for 12 months and frames for 24 months – Elective—Purchase and exam covered up to $75; if you do not obtain contact lenses through a prescribing doctor, you may be required to pay an evaluation and fitting fee – Visually Necessary—Covered in full only with prior authorization from VSP and when obtained from a participating doctor

* *You are responsible for charges in excess of allowable expenses in addition to the cost of cosmetic extras not covered by the plan, such as blended, tinted or oversized lenses.*

For a list of VSP providers, call 1-800-877-7195 or visit VSP on the Web at *www.vsp.com*. When you make an appointment, be sure to identify yourself as a VSP member.

Life Insurance

When you reach regular status, you'll be able to choose from four different levels of life insurance coverage.

PG&E provides the first $10,000 of coverage—called Basic Life—at no cost to you. The remaining coverage amounts listed below include the $10,000 Basic Life coverage:

- $50,000
- One and a half times your Base Annual Earnings
- Two times your Base Annual Earnings.

Your cost to purchase additional coverage is $0.04 per $100 of coverage in excess of Basic Life.

The Internal Revenue Service (IRS) requires you to pay "imputed income taxes" on the value of your life insurance over $50,000. The amount on which you must pay taxes is automatically calculated at rates determined by the IRS and then added to your gross income.

CHANGING YOUR COVERAGE

Regular status employees cannot request life insurance coverage changes during the Open Enrollment period. However, you may request to buy additional coverage at any time during the year by contacting Metropolitan Life Insurance Company ("MetLife") at 1-888-878-8490, or by accessing the MyBenefits Web site.

The coverage increase you request may require approval by MetLife. If you elect an amount of coverage that requires approval, MetLife will send you a *Statement of Health* (SOH) form, which you will need to complete and return.

If MetLife requires a physical examination in order to make its determination, the examination will be at your own expense. After MetLife receives complete information from you and your doctor (if required), you will receive notification of their decision to approve or deny your request. If you fail to submit evidence of good health, your coverage will not increase.

MyBenefits WEB SITE

You can perform a variety of self-service activities on MetLife's *MyBenefits* Web site. To register for MyBenefits, go to: *https://mybenefits.metlife.com/MyBenefits/ssi/commonAccess.do*. Use "Pacific Gas and Electric Company" when prompted for the company name.

Once you are registered, you can:

- Enroll online. If you are a regular status employee, you may enroll online for any of the life insurance options shown above. However, if your enrollment is subject to eligibility limitations, you may receive additional communications from MetLife. For example, if you are not eligible for the amount of insurance you choose, you will receive an explanation. Or, if you are required to complete a *Statement of Health* (SOH) form, MetLife will send you the appropriate form
- View and print a copy of your life insurance certificate
- Check your current coverage and cost
- Name, change or review your beneficiary(ies).

For assistance, contact MetLife at 1-888-878-8490.

FREE HELP PREPARING YOUR WILL

If you choose more than $10,000 in employee life insurance coverage for 2009, you can participate in a special program offered by Hyatt Legal Plans (a MetLife company). At no cost to you, the program allows you and your spouse or registered domestic partner to obtain assistance in preparing your will from one of 9,000 attorneys nationwide.

To use this program, contact Hyatt Legal Plans toll-free at 1-800-821-6400. Client services representatives are available Monday through Thursday from 5 a.m. to 4 p.m. and on Friday from 5 a.m. to 3 p.m. Pacific Time. Please be prepared to provide the PG&E life insurance group number (74304) and your Social Security number. After verifying your eligibility, the client services representative will provide you with a case number and help you locate a participating attorney in your area.

This benefit covers the preparation or updating of wills, not preparation of living trusts. Please consult with an attorney to determine whether a living trust or a will is more appropriate for you.

Flexible Spending Accounts (HCRA & DCRA)

The Health Care Reimbursement Account (HCRA) and Dependent Care Reimbursement Account (DCRA) are valuable options for you to consider. These Flexible Spending Accounts (FSAs) can reduce your taxable income by allowing you to pay for many out-of-pocket health care and dependent care expenses with before-tax dollars.

The money you contribute is deducted from your pay in equal amounts throughout the year. Your FSA money is before-tax—that is, contributions are taken out before federal, state, Social Security and local taxes are withheld. Before you make your FSA elections, be sure to estimate your yearly expenses as best as you can, because IRS rules require that any unused balances in your FSA accounts at the end of the plan year are forfeited. Use the Savings Calculator, available at *www.connectyourcare.com/eecalculators,* to help you. The calculator will also show your potential tax savings when you contribute to an FSA.

You will be reimbursed from your account in before-tax dollars when you incur an eligible expense. Reimbursement checks can be mailed to your home or deposited directly into your bank account if you sign up for direct deposit.

The HCRA and DCRA are separate; you may sign up for either or both. And you must sign up to participate each calendar year.

HOW MUCH CAN YOU CONTRIBUTE EACH YEAR?

REIMBURSEMENT ACCOUNT	CONTRIBUTION MAXIMUM
Health Care	$5,000 maximum per individual or married couple filing joint tax return (employees with opposite-sex spouses* filing separate returns may each contribute up to $2,500)
Dependent Care	$5,000 maximum per individual or married couple filing joint tax return (employees with opposite-sex spouses* filing separate returns may each contribute up to $2,500) Your annual contributions to the dependent care account cannot exceed your opposite-sex spouse's income. If your opposite-sex spouse is a full-time student or 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.

* *The contribution rules for married individuals do not apply to employees with same-sex spouses.*

WHEN YOUR CONTRIBUTIONS ARE AVAILABLE FOR REIMBURSEMENT

For the HCRA, the full amount of your annual contribution is available immediately to reimburse your claims incurred for the year in which you are participating. For the DCRA, you will be reimbursed up to the amount actually in your account; any remaining amount will be automatically paid during the next processing cycle or after sufficient contributions are deposited in your account. HCRA and DCRA claims will be processed daily.

HEALTH CARE REIMBURSEMENT ACCOUNT (HCRA)

The HCRA allows you to pay certain out-of-pocket health care expenses, such as medical, dental and vision deductibles, coinsurance and copayments, with before-tax dollars. Your HCRA can also cover major expenses that are typically not covered by health plans, such as Lasik eye surgery, dental implants or hearing aids.

HCRA-eligible expenses generally are the same as those approved by the IRS for tax deduction, except that salary contributions toward health care premiums are not eligible. Although over-the-counter (OTC) (non-prescription) drug expenses are not eligible for IRS tax deductions, some may be eligible for HCRA reimbursement. For information on which OTC drugs may be eligible for reimbursement, visit *www.connectyourcare.com* or call 1-888-439-5121.

A complete list of eligible expenses is available on the HR intranet under **Plans, Policies & Forms > Health & Welfare Benefits**, or from ConnectYourCare at *www.connectyourcare.com*. You can also access more information about how to pay for health care expenses at different locations (such as at your doctor's office or at the pharmacy) online.

Filing Claims for 2008

If you also enrolled in an HCRA during the 2008 Open Enrollment period, the same grace period applies as in 2008. You may submit claims until March 31, 2009, for expenses incurred through March 15, 2009, and be reimbursed with unused 2008 funds.

Submit your paper claims request with applicable receipts for the 2008 plan year to Ceridian (former plan administrator).

HCRA Deadline for Submitting 2009 Claims

You have until March 31, 2010, to submit eligible HCRA expenses incurred in 2009. Unlike the DCRA, a grace period applies: in addition to your 2009 expenses, you can also submit expenses you incur through March 15, 2010.

DEPENDENT CARE REIMBURSEMENT ACCOUNT (DCRA)

The DCRA allows you to pay certain dependent care expenses, such as daycare, babysitting and eldercare, with before-tax dollars. If you are married, both you and your spouse must be actively at work or attending school to be eligible for DCRA reimbursement, unless one of you is disabled. If one spouse is at home (for example, on maternity leave), daycare expenses are not eligible for reimbursement. For details, refer to IRS Publication 503, Child and Dependent Care Expenses, on the IRS Web site at *www.irs.gov*, or call the IRS toll-free at 1-800-829-3676.

Both the DCRA and the Federal Dependent Care Income Tax Credit can lower your tax bill, but in different ways. If you have more than one child, you may use both methods under certain circumstances. If you have only one child, you may use only one of the two methods. Your tax advisor can help you make a decision that will maximize your DCRA tax savings.

Filing Claims for 2008

You have until March 31, 2009, to submit eligible DCRA expenses incurred through December 31, 2008.

Submit your paper claims request with applicable receipts for the 2008 plan year to Ceridian (former plan administrator).

DCRA Deadline for Submitting 2009 Claims

You have until March 31, 2010, to submit eligible DCRA expenses incurred in 2009. Expenses that are incurred after December 31, 2009, will not be eligible for reimbursement from your 2009 DCRA account.

Logging on to Your FSA Account for the First Time?

1. *Go to* **https://secure.connectyourcare.com/portal/CC**
2. *Select the log-in link from the upper right hand corner*
3. *Choose New User Registration to select your username and password*

Once logged on, you can easily access your account balance, enter a new claim and view the reimbursement schedule.

HOW TO PAY FOR ELIGIBLE EXPENSES

Accessing and using your FSA funds is easy. There are two ways to pay for eligible expenses:

1. Use the healthcare payment card ConnectYourCare will automatically send you to pay for health care expenses. Be sure to keep your itemized receipt as documentation. A claim is automatically generated when you use your card. Details on how to use your payment card are available at *www.connectyourcare.com*.

2. Pay for out-of-pocket expenses using your own personal credit card, cash or check, and keep your itemized receipt as documentation. Then, log on to your online account to file for reimbursement. Print the claim submission form and submit documentation via fax or mail. You can receive reimbursement funds via check or direct deposit. You must file all dependent care expense claims using this process.

Things to remember about your payment card...

Although your payment card eliminates the need to file paper claims, the IRS requires that your charges be verified. Always save your receipts for tax purposes in case ConnectYourCare or the IRS requests them to confirm a purchase. If a receipt is needed, you will also be notified by e-mail or letter within a week of your payment card swipe. More information about how to submit expenses and which merchants will accept the payment card is available at *www.connectyourcare.com*.

Advantages of Using Your Healthcare Payment Card:

- *It's easy. Swipe your card to pay for eligible expenses—the money is taken straight out of your HCRA account*
- *It's convenient. The card is approved by most major doctors' offices, hospitals and pharmacies*
- *It's fast. Just be sure to save your receipts.*

Your account balance is available at any time online, or over the phone.

Comparison of Medical Benefits

The information in this chart is intended as a high-level summary only. The information contained in an applicable service provider agreement between PG&E and Anthem Blue Cross shall govern in case of conflict between this chart and the service provider agreement.

PROVISIONS	NETWORK ACCESS PLAN (NAP) ADMINISTERED BY ANTHEM 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 on benefits; no pre-existing condition exclusions All plan benefits and out-of-pocket maximums are based on Eligible Expenses only*
Hospital Stay	100% after $100 copay; preauthorization required for nonemergency care, $300 penalty if not obtained; covers semiprivate room (private if Medically Necessary); includes intensive care	70%; preauthorization required for nonemergency care, $300 penalty if not obtained; covers semiprivate room (private if Medically Necessary); includes intensive care
Skilled Nursing Facility	90% for semiprivate room after three days in hospital; preauthorization required, $300 penalty if not obtained; excludes custodial care	70% for semiprivate room after three 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 medical emergency, 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%

PROVISIONS	NETWORK ACCESS PLAN (NAP) ADMINISTERED BY ANTHEM BLUE CROSS	
	Network	***Non-Network***
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 24 for details	Covered by separate drug plan administered by Medco Health; see page 24 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 Anthem 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 Anthem Blue Cross. Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Anthem Blue Cross Member Services.*

Comparison of Medical Benefits

The information in this chart is intended as a high-level summary only. The information contained in an applicable service provider agreement between PG&E and Anthem Blue Cross shall govern in case of conflict between this chart and the service provider agreement.

PROVISIONS	COMPREHENSIVE ACCESS PLAN (CAP) ADMINISTERED BY ANTHEM 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 All plan benefits and out-of-pocket maximums are based on Eligible Expenses only*
Hospital Stay	100% after $100 copay; preauthorization required for nonemergency care, $300 penalty if not obtained; covers semiprivate room (private if Medically Necessary); includes intensive care
Skilled Nursing Facility	90% for semiprivate room after three 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 24 for details

PROVISIONS	COMPREHENSIVE ACCESS PLAN (CAP) ADMINISTERED BY ANTHEM BLUE CROSS
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 excludes custodial care
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 Anthem 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 Anthem Blue Cross. Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Anthem Blue Cross Member Services.*

Comparison of Medical Benefits

The information in this chart is intended as a high-level summary only. The information about the HMOs or the insured products contained in an applicable Evidence of Coverage (EOC) or service provider agreement between PG&E and the HMO or service provider shall govern in case of conflict between this chart and the EOC or service provider agreement.

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; includes intensive and coronary care	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	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 nonformulary; some drugs require preauthorization; MAILORDER (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 nonformulary; some drugs require preauthorization; MAILORDER (through the plan): two times retail copay for up to a 90-day supply; no annual maximum; open formulary

PROVISIONS	BLUE SHIELD HMO	HEALTH NET HMO
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
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	No charge; preauthorization required; see plan EOC for limitations and exclusions	No charge; see plan EOC for limitations and exclusions
Chiropractic Care	Discounts available; contact Member Services for details	Discounts available; contact Member Services for details
Acupuncture	Discounts available; contact Member Services for details	Discounts available; contact Member Services for details
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.*

Comparison of Medical Benefits

The information in this chart is intended as a high-level summary only. The information about the HMOs or the insured products contained in an applicable Evidence of Coverage (EOC) or service provider agreement between PG&E and the HMO or service provider shall govern in case of conflict between this chart and the EOC or service provider agreement.

PROVISIONS	KAISER PERMANENTE HMO NORTH AND SOUTH
General	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
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
Emergency Room Care	$25/visit for emergencies (waived if admitted directly to the hospital within 24 hours for the same condition)
Outpatient Hospital	$10 per procedure for outpatient surgery; $10/visit for all other outpatient services may apply
Maternity Care	No charge
Well-Baby Care	$10/visit
Office Visits	Office visit—$10 Home visit—No charge
Urgent Care Visits	$10/visit
Routine Physical Examinations	$10/visit
Immunizations and Injections	$10/visit for immunizations and 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
X-rays and Lab Tests	No charge
Pre-Admission Testing	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
Hospice Care	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
Outpatient Prescription Drugs	$10 copay for up to 100-day supply when obtained at a plan pharmacy or through the plan's mailorder; no annual maximum; closed formulary

PROVISIONS	KAISER PERMANENTE HMO NORTH AND SOUTH
Mental Health*	
Inpatient Care	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
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)
Outpatient Care	$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
Chiropractic Care	Discounts available; contact Member Services for details
Acupuncture	Discounts available; contact Member Services 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.*

Prescription Drug Benefits

The information in this table is intended as a high-level summary only. This table summarizes the prescription drug benefits for members enrolled in the Anthem 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 Anthem Blue Cross out-of-pocket maximum. Also, some drugs may not be covered or may require special authorization from Medco Health. For specific information about prescription drug coverage, call Medco Health's Member Services department directly, or visit its Web site at *www.medcohealth.com*.

For general information regarding the prescription drug coverage provided by each HMO, refer to Outpatient Prescription Drugs on the Comparison of Medical Benefits charts on pages 20 to 23. 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 pages 28 and 29 of this guide.

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 nonparticipating pharmacies: 80% for generics and 70% for brand names; Generic Incentive Provision applies (see below)
Mailorder 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 noncovered 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 mailorder drug benefit, but does not coordinate with medical plan. Noncovered 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 mailorder plans, unless medically necessary. Medically necessary drugs are covered at standard reimbursement rates. Generic Incentive Provision applies (see above)

Manufacturer rebates are earned upon participant purchase of certain prescription drugs. The value of these rebates is based on the contract that Pacific Gas and Electric Company, as Plan sponsor, has with Medco Health. These rebates are received from Medco Health approximately six months after the purchase of a drug and are deposited back to the trust holding the plan assets for retirees or employees on long-term disability or back to the company for active employees. The cost of the plan is reduced by the value of the rebates.

NOTES:

NOTES:

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 2009 enrollment material, including your Enrollment Worksheet, this 2009 Benefits Enrollment Guide, the Supplement to Your 2009 Benefits Enrollment Guide and your confirmation statement;
- Acknowledge that you have received the Notice about Your Prescription Drug Coverage and Medicare included at the end of the Supplement to Your 2009 Benefits Enrollment Guide;
- Authorize Pacific Gas and Electric Company, PG&E Corporation and their affiliates ("Participating Employers") 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 Participating Employers to deduct any required before-tax or after-tax contributions from your pay;
- Acknowledge that unless you experience an eligible change-in-status event, you will not be able to change medical plans during 2009 (a change-in-status event does not occur if your desired physician, hospital, medical group or Independent Physician Association (IPA) does not participate in or terminates its relationship with your medical plan's network);
- Acknowledge that any current HCRA/DCRA elections cannot automatically roll forward into 2009 and that you must actively re-enroll to make new HCRA/DCRA elections for 2009;
- Acknowledge that PG&E, the other Participating Employers and the health plan administrators and insurers do not provide medical services or make treatment decisions; all treatment decisions are between you and your physician regardless of the benefits covered under the plan;
- Agree to follow the appeal process for your plan for any disputed benefit claims; and
- Agree to call the HR Service Center to report any ineligible dependents within 31 days of a dependent's loss of eligibility.

PG&E BENEFITS INFORMATION AND REFERENCES

PG&E HR Service Center	E-mail: *hrbenefitsquestions@exchange.pge.com* Phone: 415-973-4357 or 1-800-788-2363
***PG&E@Work For Me* (on the company intranet)** ***PG&E@Work For Me* on the Internet**	*http://pgeatworkforme* *https://myportal.pge.com*
HR Intranet Site	*http://www/hr/index.shtml*
PG&E's Summary of Benefits Handbook	Available on the HR intranet site. You can also obtain a paper or CD-ROM copy free of charge by calling the HR Service Center
IRS Publications	*www.irs.gov*

MEMBER SERVICES CONTACTS

Plan	Phone No.	Web Site	Group No.
Blue Shield HMO and Medicare COB HMO	1-800-443-5005	www.blueshieldca.com/pge	**HMO**: IBEW- and SEIU-represented employees: H11871 ESC-represented employees: H11872 **Medicare COB**: H11473
Dental Plan (Administered by Delta Dental)	1-888-217-5323	www.wekeepyousmiling.org/PG&E	IBEW- and SEIU-represented employees: 1515-0101 ESC-represented employees: 1515-0106
Employee Assistance Program	1-888-445-4436	http://www/HR/PlansPolicies/HealthWelfareBenefits.shtml **or** www.achievesolutions.net/pge	

Continued

SUMMARY OF MATERIAL MODIFICATIONS (OCTOBER 2008)

The 2009 Benefits Enrollment Guide and Supplement constitute a Summary of Material Modifications to the Pacific Gas and Electric Company Health Care Plan for Active Employees and the Pacific Gas and Electric Company Health Care Reimbursement Account Plan (collectively, "The Plans").

Pacific Gas and Electric Company has the right to amend or terminate The Plans at any time and for any reason, subject to notice provisions if such notice is required under applicable collective bargaining agreements. Generally, an amendment to or termination of The Plans will apply prospectively and will affect your rights and obligations under The Plans prospectively.

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MEMBER SERVICES CONTACTS

Plan	Phone No.	Web Site	Group No.
Flexible Spending Accounts (Administered by ConnectYourCare)	1-888-439-5121	www.ceridian-benefits.com for 2008 claims and 2009 grace period claims www.connectyourcare.com or https://secure.connectyourcare.com/portal/CC for 2009 claims	
Health Net HMO and Medicare COB HMO	1-800-522-0088	www.healthnet.com/pge	**HMO**: IBEW- and SEIU-represented employees: 68990A ESC-represented employees: 68991A **Medicare COB**: 68992M
Health Net Seniority Plus	Current members: 1-800-275-4737 Prospective members: 1-800-596-6565	www.healthnet.com/pge	68992S
Kaiser Permanente (North and South) HMO	1-800-464-4000	www.my.kaiserpermanente.org/ca/pge	**North**: IBEW- and SEIU-represented employees: 28-0000 ESC-represented employees: 28-0100 **South**: IBEW- and SEIU-represented employees: 107932-0000 ESC-represented employees: 107932-0100
Kaiser Permanente Senior Advantage (North and South)	1-800-443-0815	www.my.kaiserpermanente.org/ca/pge	**North**: 738-0001 **South**: 107932-0002
Mental Health, alcohol and drug care program (Administered by ValueOptions)	1-800-562-3588	www.valueoptions.com	
PG&E Self-Funded Plans (Administered by Anthem Blue Cross) Network Access Plan (NAP) Comprehensive Access Plan (CAP) American Specialty Health Network (ASHN)	1-800-964-0530 1-800-678-9133	www.anthem.com/ca **or** www.anthem.com/ca/pge www.ashcompanies.com	PZG170157
Prescription Drug Plan (Administered by Medco Health)	1-800-718-6590	www.medcohealth.com	PGE0000
Life Insurance (Administered by MetLife)	1-888-878-8490	www.metlife.com **or** https://mybenefits.metlife.com/MyBenefits/ssi/commonAccess.do	74304
Free Will Preparation Services (Hyatt Legal Plans)	1-800-821-6400		74304
Vision Plan (Administered by Vision Service Plan)	1-800-877-7195	www.vsp.com	401601 – Div 6, Class 3
COBRA (Administered by Ceridian)	1-800-877-7994	www.ceridian-benefits.com