PG&E@Work

SUPPLEMENT TO YOUR 2008 ENROLLMENT GUIDE

Energize Your Life

2008

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Summary of Material Modifications (October 2007)

The 2008 Enrollment Guide and Supplement constitute a Summary of Material Modifications to the PG&E Health Care Plans.

The Management and Administrative & Technical Benefits Enrollment Guide, the Employees Represented by the IBEW and SEIU Benefits Enrollment Guide, the Employees Represented by the ESC Benefits Enrollment Guide, the Retiree and Surviving Dependents Medical Care Enrollment Guide and the Supplement to Your 2008 Enrollment Guide (referred to collectively as the "Enrollment Guides") are designed, in part, to: (1) 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 Plan for Retirees and Surviving Dependents (referred to as the Health Care Plans), (2) to provide you with answers to some common questions which arise in connection with enrollment in the Health Care Plans, and (3) to provide you with some important information about your rights under the Health Care Plans. The Enrollment Guides are not an exhaustive explanation of the Health Care Plans. Additional information about the Health Care Plans are contained in the documents entitled "The Pacific Gas and Electric Company Health Care Plan for Active Employees," "The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents," the Summary of Benefits Handbook and the Summaries of Material Modifications, including enrollment guides designated as Summaries of Material Modifications, as well as the Evidence of Coverage booklet issued by HMOs and the Blue Cross SmartValue Plan, which collectively constitute the official plan document.

Pacific Gas and Electric Company is the Plan Administrator of the Health Care Plans and has the discretionary authority to interpret and construe the terms of the official plan document, to resolve any conflicts or discrepancies between the documents which comprise the official plan document, and to establish rules which are necessary for the administration of the Health Care Plans.

INTRODUCTION

This supplement to your 2008 Enrollment Guide includes detailed information about eligibility, change-in-status events and COBRA, as well as other legally required information for the following benefit programs:

The Pacific Gas and Electric Company Health Care Plan for Active Employees, The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, The Pacific Gas and Electric Company Health Care Reimbursement Account Plan, The Pacific Gas and Electric Company Dependent Care Reimbursement Account Plan, and The Pacific Gas and Electric Company Flex Plan for Management Employees.

Certain plans are referred to herein collectively as "PG&E's Health Care Plans." These are the plans which provide medical, mental health, prescription drug, dental and vision coverage as well as the flexible spending account plans.

PARTICIPATING EMPLOYERS

The Employers participating in the 2008 health plan Open Enrollment are:

- Pacific Gas and Electric Company (PG&E)
- PG&E Corporation
- PG&E Corporation Support Services, Inc.
- PG&E Corporation Support Services II, Inc.

ELIGIBILITY

Eligibility for Employees

You and your eligible dependents may enroll in PG&E's benefit plans if you are a full-time or part-time Management, Administrative & Technical or union-represented employee of a Participating Employer. Your employment status (non-union-represented or union-represented), whether you work for PG&E Corporation, Pacific Gas and Electric Company or another Participating Employer, as well as your home ZIP code determine your eligibility for certain plans.

Eligibility for Retirees

Employees Who Retired Prior to 2004

If you retired prior to January 1, 2004, you are automatically eligible for PG&E retiree medical plan coverage, unless you dropped coverage prior to January 1, 2003. (Note: Retirees who dropped coverage prior to 2003 are not eligible to re-enroll for PG&E-sponsored medical coverage at any time.)

Employees Who Retired in 2004 or Later

Union-represented employees who retired January 1, 2004, or later, and all non-union-represented employees who were hired January 1, 2004, or later must have at least ten years of credited service upon retirement to be eligible for PG&E-sponsored retiree medical plan coverage.

Non-union represented employees who were hired prior to January 1, 2004, are eligible for PG&E-sponsored retiree medical plan coverage upon retirement, regardless of years of credited service. However, a minimum of ten years of credited service is required to qualify for the one-time 50 percent Retiree Premium Offset Account (RPOA50) allotment.

Re-Enrolling after Waiver of Medical Coverage

Retirees who waive medical plan coverage on or after January 1, 2003, are allowed to re-enroll in a PG&E-sponsored medical plan during any subsequent Open Enrollment period. To initiate re-enrollment, you must call the Benefits Service Center to request an Open Enrollment packet no later than September 1 of the year prior to the year for which you want to re-enroll. An enrollment packet will be mailed to your home immediately prior to Open Enrollment. Any coverage you elect during Open Enrollment will be effective the following January 1.

If you do not notify the Benefits Service Center by September 1, you will not be able to re-enroll for the upcoming year — even if you waived PG&E-sponsored coverage because you had other medical coverage and you subsequently lose that other coverage.

Please note that retirees who dropped PG&E-sponsored retiree medical plan coverage prior to January 1, 2003, are not eligible to re-enroll for PG&E-sponsored medical plan coverage at any time.

Non-Payment of Premiums

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

Eligibility for Surviving Dependents

As a surviving dependent (spouse, domestic partner or eligible dependent child) of an employee or retiree, you are eligible for continued medical plan coverage if you were enrolled in a PG&E-sponsored medical plan at the time of the employee's or retiree's death and you are not covered under another group plan (other than Medicare). If you are a surviving dependent child, you must also meet other eligibility criteria (please contact the Benefits Service Center for more information).

If You Get Married or Acquire a Domestic Partner

Surviving dependents who get married or enter into a registered domestic partnership are no longer eligible to be covered under a PG&E-sponsored medical plan, even if the new spouse or domestic partner has no other medical coverage. If you get married or enter into a registered domestic partnership, please notify the Benefits Service Center immediately to avoid penalties.

Cancellation

Surviving dependents who waive medical plan coverage will not be able to enroll in a PG&E-sponsored medical plan again at any time in the future.

Premiums

Surviving dependents pay the full cost of their required medical plan premiums; the Participating Employer does not make any contributions towards the cost.

Non-Payment of Premiums

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

Eligible Dependents

If, after reviewing the information below, you have questions about whether or not a dependent is eligible for coverage, please call the Benefits Service Center.

Eligible dependents include one or more of the following:

- Your legally married spouse or registered domestic partner
- 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 (for employees and retirees only) (a child for whom your registered domestic partner is the legal guardian is not an eligible dependent)

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- Your unmarried, dependent children or those of your spouse/registered domestic partner who are age 19 through 23 and meet the Internal Revenue Service (IRS) definition of an eligible dependent, whether or not you claim them as dependents on your income tax returns
- 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.) before they would otherwise cease to qualify as dependents, and who have been approved by a PG&E-sponsored medical plan vendor for continued coverage. For more information, please contact the Member Services department for the medical plan in which you are enrolled.

Dependent Certification

If you have a child who is between the ages of 19 and 23, please be aware that you will be asked by your medical plan vendor to re-certify your child's status as an IRS-eligible dependent each year. Be sure to respond in a timely manner, or your dependent's coverage will be dropped. If your dependent becomes ineligible, you must notify the Benefits Service Center at the phone number shown on page 11 within 31 days of your dependent's loss of eligibility.

Domestic Partner Tax Certification

If you want 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. In addition, there may be tax implications for you. For details on domestic partner registration and benefits, access a copy of *Your Guide to Domestic Partner Benefits at Pacific Gas and Electric Company* on PG&E's HR intranet. Go to the **Life Changes > When You Form a New Domestic Partnership** section of the HR Intranet. Or call the Benefits Service Center for a copy of the guide.

It is important to note that the cost of benefits provided for a domestic partner and any covered dependent children of a domestic partner are treated as imputed federal income and are subject to tax withholding, unless your domestic partner or the children of your domestic partner qualify as IRS dependents. 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 Benefits Service Center to request a form. Forms received after December 31, 2007, will not be processed for 2008. In addition, California partnerships that are registered with California's Secretary of State may be exempt from state income tax on imputed income for domestic partner benefits if certain conditions are met. Please contact the Benefits Service Center for more information.

National Medical Support Notices

If a Participating Employer receives a court-ordered judgment or decree requiring you to cover an eligible dependent child, the child will be enrolled in your health care plans[1], pursuant to the court order or judgment. Coverage for the child will be effective the first of the month following enrollment by PG&E, and your health plan premium costs will be adjusted to reflect the coverage of the child, if applicable. If you are enrolled in a Health Maintenance Organization (HMO) and your child does not live within your HMO's service area, you will be switched to the Network Access Plan (NAP) or the Comprehensive Access Plan (CAP), as applicable for your family's ZIP code. You will also have to pay the required contributions associated with the NAP and CAP plans.

Domestic Partner Dependents

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

[1] A Qualified Medical Child Support Order (QMCSO) will not automatically enroll you in the Health Care Reimbursement Account Plan.

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IMPORTANT

If both you and your spouse or registered domestic partner are an employee or retiree of a Participating Employer, only one of you may enroll each child as an eligible family member under any one benefit plan.

Ineligible Dependents

Ineligible dependents include, but are not limited to:

- A divorced, legally separated, 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
- Parents, step-parents, parents-in-law, grandparents and step-grandparents
- Former step-children or the step-children of a former domestic partner, unless they were born or adopted during the course of the domestic partnership or you have been appointed permanent legal guardian 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 dependent children 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 a PG&E-sponsored medical plan vendor 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 employee or retiree of a Participating Employer
- Grandchildren, nieces, nephews or other family members, unless you have legally adopted them or have been appointed permanent legal guardian for them by a court
- A family member who is a non-union-represented employee of a Participating Employer. Each non-union-represented employee must enroll separately as an employee. (If you and your family member or domestic partner are both union-represented employees or are retirees, you each have the option of being covered as an "employee" or "retiree," or you can be covered as a "dependent" of the other. However, you may not be covered as both.)

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. All participants who cover ineligible dependents will be required to make restitution to the Participating Employer for health care coverage. Effective July 1, 2007, PG&E began requiring up to two years' restitution for the insured or HMO premiums (or self-insured premium equivalents) attributable to coverage of ineligible dependents. Restitution is no longer capped at $7,500.

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

To drop ineligible dependents, call the Benefits Service Center at the phone number shown on page 11.

CHANGE-IN-STATUS EVENTS

What's a Change-in-Status Event?

A change-in-status event is a life event that allows you to make certain changes in your benefits elections after the plan year has begun. Only certain change-in-status events are recognized and only limited changes in your benefit elections are permitted, due to restrictions imposed by federal legislation governing the administration of pre-tax benefit plans like those sponsored by PG&E. For example, for active employees, your pre-tax contributions, e.g., amounts contributed to a flexible spending account, cannot be altered when the change-in-status event is due to a change in status relating to a domestic partnership. Eligible change-in-status events are listed below.

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 a change-in-status event that will allow a change, or
- you retire.

Any changes that you request generally must be consistent with your change-in-status event. For example, if you move out of your HMO's service area, you may change your medical plan, but you cannot add new dependents. The only exception is when you experience one of the events that trigger the Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment Rights (see page 6 for more information). For instance, if you are an employee and 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. In addition, if your enrolled child begins attending college outside of your HMO's service area, you may change your medical plan only.

Note: The withdrawal of a provider, such as a doctor, medical group or hospital, 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.

Eligible Change-in-Status Events

Change-in-status events include:

- Marriage or the establishment of a registered domestic partnership (for employees and retirees only)
- Dissolution of marriage (including final divorce or annulment), legal separation or termination of a domestic partnership. Please note that you cannot cover your ex-spouse or former domestic partner on your PG&E-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 legal guardianship for a child
- The death of your spouse, registered domestic partner or dependent child
- Your dependent child reaching the plan's age limit, getting married or entering the military
- Your dependent child regaining eligibility
- You or your dependent becoming Medicare- or Medicaid-eligible
- A change of caregivers, or a change in the cost for the services of a caregiver who is not a relative (for Dependent Care Reimbursement Account (DCRA) purposes only)
- A move out of your HMO's service area (applies to change of medical plan only)

Additional change-in-status events which apply to employees only include:

- A change in the employment of your spouse, registered domestic partner or dependent that results in a gain or loss of health care coverage
- A change to or from full-time or part-time employment by you, your spouse, registered domestic partner or dependents, if health plan eligibility is affected*
- An unpaid leave of absence taken by you, your spouse or registered domestic partner that significantly impacts the cost of your health care coverage*

* Change–in-status events are allowed for retirees who are already enrolled whose spouse or domestic partner has a change to or from full-time or part-time employment or takes an unpaid leave of absence.

Move Out of HMO Service Area

If you or your dependent moves out of your HMO's service area, you must call the Benefits Service Center within 31 days to select a new medical plan. If you don't, the medical services you or your dependent receive may not be covered. For more details, refer to your Summary of Benefits Handbook.

IMPORTANT

Call the Benefits 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 Health Care Reimbursement Account (HCRA) or Dependent Care Reimbursement Account (DCRA) until the next Open Enrollment period. Enrollment will be effective the first of the month following timely notification, except for when you are adding newborns and newly adopted children, as explained below.

Important Information About Adding Newborn or Newly Adopted Children

To ensure that your child has continuous health coverage from birth or adoption, you must call the Benefits 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 as of the 61st day for the self-insured Blue Cross medical plans and retroactive to the date of birth or adoption for the HMO plans and the SmartValue Plan, and any expenses incurred for your child will not be covered. Also, 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 1, 2008, and you may have a gap in coverage. In all cases, please call the Benefits Service Center promptly to add new children.

HIPAA SPECIAL ENROLLMENT RIGHTS FOR EMPLOYEES

If you are declining PG&E-sponsored health care coverage for yourself or your dependents (including your spouse) because you have other health insurance coverage, you may be able to enroll yourself and your dependents in PG&E-sponsored health care plans if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, you must request enrollment within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, domestic partnership, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days of the date of your marriage or domestic partnership registration, and within 60 days of the birth, adoption or placement for adoption of a child.

To request special enrollment or obtain more information, contact the Benefits Service Center.

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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 PG&E-sponsored 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

Loss of PG&E-sponsored group health plan coverage due to the following events are COBRA-Qualifying Events:

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

PG&E and the other Participating Employers extend the same type of coverage rights to registered domestic partners and their children that they would extend to qualified beneficiaries under COBRA. Qualifying events to obtain this COBRA-like coverage are the same for registered domestic partners as for spouses, including the dissolution of a registered domestic partnership.

Qualified dependents must be covered under your plan immediately 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 the health care expenses of 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 COBRA-qualifying events and specific notification to PG&E. If you are dropping a dependent during the Open Enrollment period and are unsure whether or not your dependent is eligible for COBRA due to a qualifying event, please contact the Benefits Service Center at the phone number shown on page 11.

If you divorce, legally separate or dissolve a domestic partnership, or if a dependent child no longer qualifies as an eligible dependent under the plans, you must call the Benefits Service Center to request COBRA enrollment materials within 60 days of occurrence of the COBRA-qualifying event or the last day of eligible coverage—whichever occurs last. **A Benefits Service Center representative will provide you with a COBRA Notification Confirmation Number which you should retain until you have received your COBRA enrollment materials. This number will serve as confirmation that you provided timely notification, as required by PG&E policy.**

If you are an employee and die or lose health coverage through PG&E or another Participating Employer, Ceridian will automatically provide you or your dependents with COBRA enrollment materials. If you are a retiree and die, your dependent should contact the Benefits Service Center to request COBRA enrollment materials.

If Your COBRA HMO Coverage 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 in their HMO 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.

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For application materials, cost or additional information, contact your HMO at least 60 days before your current COBRA coverage terminates. The cost and coverage of any HIPAA Guaranteed Issue individual plan may vary considerably from your COBRA plan.

If you are a Blue Cross member and your COBRA coverage is ending, you may also contact Blue Cross to request coverage under a HIPAA Guaranteed Issue Plan. Contact Blue Cross at least 60 days before your COBRA coverage ends. The cost and coverage of any HIPAA Guaranteed Issue individual plan may vary considerably from your COBRA plan.

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.

IMPORTANT

To request continued coverage through COBRA, you must notify the Benefits Service Center within 60 days of losing coverage.

WOMEN'S MASTECTOMY AND HEALTH RIGHTS

The Women's Health and Cancer Rights Act of 1998 mandates that group health plans covering mastectomies pay for certain reconstructive and related services following a mastectomy. For an individual 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 lymphedema.

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.

NEWBORN'S MOTHER HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE FROM PACIFIC GAS AND ELECTRIC COMPANY AND MEDICARE (FOR MEDICARE-ELIGIBLE PARTICIPANTS)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under plans sponsored by Pacific Gas and Electric Company (PG&E) and your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. You will find information about where to get help with making decisions about your prescription drug coverage at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage through Medicare. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. PG&E has determined that the prescription drug coverage offered by the Pacific Gas and Electric Company Medical Plan for Active Employees and by the Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered "Creditable Coverage." Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (penalty) if you later decide to enroll in a Medicare prescription drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year thereafter from November 15 through December 31. This may mean that you have to wait to join a Medicare drug plan and that you may pay a higher premium (penalty) if you join later. You may pay that higher premium (penalty) for as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage through no fault of your own, you will be eligible for a sixty (60)-day Special Enrollment Period (SEP) to join a Part D plan because you lost creditable coverage. In addition, if you lose employer coverage or decide to not enroll in a PG&E-sponsored plan, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered and at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your PG&E-sponsored prescription drug coverage, be aware that retirees and Long-Term Disability participants and their dependents will not be able to re-enroll in a PG&E-sponsored plan until the next Open Enrollment Period. Surviving dependents who drop coverage will not be able to re-enroll in a PG&E-sponsored plan at any time.

If you decide to join a Medicare prescription drug plan, your PG&E coverage will be affected. Please read the following and contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

PG&E-sponsored health plan options that are available to retirees, surviving dependents and employees on Long-Term Disability are explained in the 2008 Enrollment Guides. Your current coverage pays for other health expenses in addition to prescription drugs. You will not be eligible to keep your current health and prescription drug benefits if you choose to enroll in a Medicare Part D prescription drug plan outside of PG&E's Open Enrollment process.

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

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up by at least one percent per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will consistently be at least 19 percent higher than the base beneficiary premium. You may have to pay this

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higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage, contact the Benefits Service Center at the phone number shown on page 11.

NOTE: You will receive this notice each year. You will also receive it before the next period during which you can join a Medicare prescription drug plan, and if your coverage through PG&E changes. You also may request a copy at any time.

For more information about your options under Medicare prescription drug coverage, see the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit *www.medicare.gov*
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for the telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at *www.socialsecurity.gov,* or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

October 2007
Pacific Gas and Electric Company
1850 Gateway Blvd., 7th Floor
Concord, CA 94520
415-973-2363

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HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

This notice is to remind you of the availability of the HIPAA Notice of Health Information Privacy Practices ("HIPAA Notice") for The Pacific Gas and Electric Company Health Care Plan for Active Employees, The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, and The Pacific Gas and Electric Company Health Care Reimbursement Account Plan ("The Health Care Plans"). The HIPAA Notice was originally provided to you at the later of (a) the time you became an eligible participant or (b) in 2003 when the Plan implemented the privacy requirements of the Health Insurance Portability and Accountability Act of 1996.

The HIPAA Notice, which is posted on the HR intranet site in the **Plans, Policies & Forms** section or is available upon request, describes how personal health information about you on file with the Health Care Plans may be used and disclosed, as well as how you can access your personal health information. In general, your individual health information may be used and disclosed by the Health Care Plans for purposes of treatment, payment and operations, as well as other uses and disclosures allowed and/or required by law.

To receive more information about the Health Care Plans' health information privacy practices or HIPAA rights, or if you or your eligible dependents have any questions about the HIPAA Notice, you may contact the Pacific Gas and Electric Company Plan Administrator, Benefits Department, 1850 Gateway Boulevard, 7th Floor, Concord, CA 94520.

BENEFITS SERVICE CENTER CONTACT INFORMATION

Active Employees and Employees on Leave or Long-Term Disability

PG&E company extension: 8-223-2363
External numbers: 415-973-2363 or 1-800-788-2363

Retirees and Surviving Dependents

415-972-7077 or 1-800-700-0057

E-mail: *hrbenefitsquestions@pge.com*

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