May 12, 2009

PG&E Employee:

The enclosed *Summary of Material Modifications for Employees Represented by the IBEW, ESC or SEIU* booklet describes changes to your health care plans and to the retirement plan for the 2009 plan year. The section on PG&E's Flexible Spending Accounts (FSAs) provides more detail than what was provided in your 2009 Benefits Enrollment Guide. The other health care benefit changes such as the COBRA updates are a result of new federal stimulus legislation.

The information in the booklet is separate from any proposed changes being discussed through the Benefits Re-Opener negotiations. Information about any changes to your benefit plans that are ratified through the Benefits Re-Opener will be mailed to you at home. Updates on the Benefits Re-Opener, including links to the proposals, are available on the HR intranet site in the **Union Information > Union Updates** section.

Questions?
If you have questions about the enclosed materials, please contact the HR Service Center at 415-973-4357 or 1-800-788-2363. You can also send your questions via e-mail to *HRBenefitsQuestions@exchange.pge.com*.

Thank you,

PG&E Benefits Department

Summary Material Modification to the Summary of Benefits Handbook

Employees Represented by the IBEW, ESC or SEIU

This booklet describes important changes to your health care plans and to the retirement plan that are effective in 2009. This document is being provided to you as a supplement to the Open Enrollment materials that were sent to you in the fall of 2008 and also as an update, or "Summary of Material Modifications," to your *2008 Summary of Benefits Handbook*. Please keep this information for future reference.

Questions? Send your questions by e-mail to *HRBenefitsquestions@exchange.pge.com* or call the HR Service Center at 415-973-4357 or 1-800-788-2363. PG&E's *Summary of Benefits Handbook* is available on the PG&E HR intranet site under **Plans, Policies & Forms > Benefit Plan Documents**, or you can request a paper or CD-ROM copy free of charge by calling the HR Service Center.

Employees Represented by the IBEW, ESC or SEIU

2009
Summary of Material Modifications

Employees Represented by the IBEW, ESC or SEIU

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Reimbursement Accounts

Reimbursement Accounts offer you a way to save on taxes when you pay for certain health care and dependent care expenses.

Summary of Material Modifications

This Reimbursement Accounts section of the booklet constitutes a Summary of Material Modifications to the Pacific Gas and Electric Company Health Care Plan for Active Employees (Plan), effective January 1, 2009.

In addition to being a Summary of Material Modifications, this Reimbursement Accounts section of the booklet completely replaces Section C of the Summary of Benefits Handbook for Employees Represented by IBEW, ESC or SEIU ("Handbook"). Unless otherwise noted, when you are referred to information in a different topic or section, the reference is to the Handbook, not this booklet.

Pacific Gas and Electric Company has the right to amend or terminate the Plan 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 plan will apply prospectively and will affect your rights and obligations under the Plan prospectively.

Summary of Benefits

The IRS allows you to pay for certain health care and dependent care services with before-tax dollars, which means these services can actually cost you less. You can enjoy this tax advantage by setting up "reimbursement accounts" each year.

You may elect to set up two different kinds of reimbursement accounts—also known as Flexible Spending Accounts (FSAs)—each year; one for health care expenses (the Health Care Reimbursement Account) and one for dependent care expenses (the Dependent Care Reimbursement Account). You put money into these accounts by contributing before-tax salary dollars from your pay. Then, when you receive an eligible health care or dependent care service, as defined by the IRS, you use these accounts to "reimburse" yourself on a before-tax basis.

If you are a Bargaining Unit employee represented by the IBEW, ESC or SEIU, you are eligible to enroll in the reimbursement accounts only during very specific times—when you are first hired, when you enroll during Open Enrollment each year, or when you have an eligible mid-year change-in-status event (see MID-YEAR ENROLLMENT CHANGES and CHANGE-IN-STATUS EVENTS under ENROLLMENT in the ABOUT YOUR BENEFITS section of the Handbook). You set up your reimbursement account(s) by designating an **annual** contribution amount when you enroll.

You are not eligible for reimbursement account benefits if you are an intern, contract or agency worker, hiring hall employee, or retired employee. Intermittent employees and other temporary employees who are not expected to become regular employees are also not eligible for coverage.

Claims Administrator

The reimbursement accounts are administered by a third-party administrator (Claims Administrator). ConnectYourCare is the third-party administrator for both the health care and dependent care accounts. If you have any questions about the Plan, IRS rules, or your claims, you may contact ConnectYourCare at 1-888-439-5121 or *www.connectyourcare.com*. Representatives are available 24 hours a day, seven days a week.

The Company[1] may reduce the amount of your contributions, stop your contributions during the year, or treat part or all of your contributions and reimbursements as taxable income to comply with applicable laws and regulations. You will be notified if your Reimbursement Accounts are affected.

How the Reimbursement Accounts Work

Setting Up Your Reimbursement Accounts

When you are first hired and during each Open Enrollment thereafter, you should estimate your anticipated out-of-pocket expenses for health care and dependent care for the upcoming year and decide how much, if anything, you wish to contribute to each account. You cannot set up or make changes to these accounts at any other time of the year, unless you have an eligible change-in-status event (see MID-YEAR ENROLLMENT CHANGES and CHANGE-IN-STATUS EVENTS under ENROLLMENT in the ABOUT YOUR BENEFITS section of the Handbook).

If you decide to set up either or both accounts, you must indicate the **annual** amount you wish to contribute. This is called your annual "goal."

- Health Care Reimbursement Account (HCRA):
  You can allocate between $50 and $5,000 a year, per individual or married couple filing a joint tax return (employees with an opposite-sex spouse filing separate tax returns may each contribute up to $2,500).

- Dependent Care Reimbursement Account (DCRA):
  You can allocate between $50 and $5,000 a year, per individual or married couple filing a joint tax return (employees with an opposite-sex spouse filing separate tax returns may each contribute up to $2,500). However, if your spouse works and has an annual income of less than $5,000, you may not contribute an amount which is more than your spouse's income. For example, if you earn $30,000 per year and your spouse earns $4,000 per year, you may contribute up to $4,000 to the DCRA, if you are filing jointly. If your spouse is a full-time student or disabled, there are special limits.

The contribution rules for married individuals **do not** apply to an employee with a same-sex spouse. See MORE ABOUT REIMBURSEMENT ACCOUNTS in this section of the booklet for additional information.

[1] Throughout this section, unless otherwise stated, reference to the "Company" or "PG&E" means Pacific Gas and Electric Company.

For more information, contact ConnectYourCare at 1-888-439-5121 or the HR Service Center at 415-973-HELP (415-973-4357) or toll-free at 1-800-788-2363.

Putting Money Into Your Reimbursement Accounts

You may contribute to the reimbursement accounts by making deposits to your reimbursement accounts through payroll deductions from your before-tax pay.

For IRS purposes, your deposits are not technically "paid" to you before going into the accounts, so they bypass all income tax withholding. Therefore, **federal income taxes, social security taxes, Medicare taxes and most state income taxes are not withheld from any of these deposits**, nor are any such taxes due when the money is used to pay for eligible expenses. You can use ConnectYourCare's FSA savings calculator at *www.connectyourcare.com/eecalculators* to estimate your potential tax savings.

Your deposits go directly into your accounts in equal portions each month. For monthly-paid employees, an equal amount will be deducted from each of your monthly paychecks before taxes. For weekly-paid employees, an equal amount will be deducted from your second paycheck of each month before taxes. By the end of the Plan year, your total contribution goal will have been placed in your account, unless you go on an unpaid leave of absence (see IF YOU TAKE A LEAVE OF ABSENCE WITHOUT PAY under MORE ABOUT REIMBURSEMENT ACCOUNTS in this section of the booklet).

Any money left in your account(s) which is not used to reimburse yourself for eligible expenses will be forfeited at the end of the Plan year, in accordance with IRS rules. However, there is a three-month "run-out" period that ends March 31 of the following Plan year, during which you can submit claims for eligible services rendered in the prior year and, for the Health Care Reimbursement Account, there is a Grace Period. See GRACE PERIOD (FOR HEALTH CARE REIMBURSEMENT ACCOUNTS) under MORE ABOUT REIMBURSEMENT ACCOUNTS – DEADLINE FOR CLAIM REIMBURSEMENTS in this section of the booklet.

Reimbursement of Eligible Health Care Expenses

You use the money in your reimbursement accounts to "pay" for eligible health care expenses as defined by section 213(d) of the Internal Revenue Code. When you obtain services that are eligible for reimbursement, you may "withdraw" the money from your HCRA.

The first step you should take when your membership in HCRA becomes effective is to **log** in to your FSA Account. (This is the same log-in process you use for accessing your DCRA as well.)

Go to *www.connectyourcare.com*. Select the log-in link from the upper right hand corner. If you are a new participant, choose New User Registration to select your username and password. Once logged in, you can easily access your account balance, enter a new claim and view the reimbursement schedule. Your account balance is available at any time online, or over the phone at 1-888-439-5121.

There are two ways to pay for eligible health care expenses:

Approach One: Use Your Healthcare Payment Card.

1. ConnectYourCare will automatically send you a healthcare payment card that you can use to pay for eligible expenses at a qualified merchant.

   Your healthcare payment card works in a fashion similar to a debit card. You can use it to pay copayments at the doctor's office, coinsurance for your prescription drugs, procedures allowed by the IRS but not covered by insurance and other similar transactions. The card has a swipe feature as well as a dedicated card number

   The card can be used to access the total value of your HCRA. However, it can only be used for merchants that have been deemed as healthcare merchants. Examples of qualified merchants may include pharmacies, doctors' offices, vision centers, and hospitals. Your payment card will automatically be activated the first time you use it.

2. Be sure to keep your itemized receipt as documentation. Although your healthcare payment card eliminates the need to file paper claims, the IRS requires that your charges be verified. **Always keep your receipts for tax purposes, in case the IRS requests them to confirm a purchase.** If ConnectYourCare needs a receipt, ConnectYourCare will notify you within a week from the date of your healthcare payment card swipe. If they have your e-mail information, notification will be electronic. Otherwise, it will be by mail.

3. If you use the healthcare payment card for an ineligible expense or for one that ConnectYourCare does not have proper documentation, you will be required to reimburse the account for the amount of that transaction.

4. If you need to order a replacement or additional healthcare payment card, you can log on to your online account or call ConnectYourCare at 1-888-439-5121 to request another card. Be sure to call ConnectYourCare promptly if your card is lost or stolen.

5. Details on how to use your healthcare payment card, more information about how to submit expenses and which merchants accept the payment card are available at *www.connectyourcare.com* or by calling ConnectYourCare at 1-888-439-5121.

Approach Two: Pay for the Expense and File a Claim

You can also pay for out-of-pocket expenses using your own personal credit card, cash or check, and keep your itemized receipt as documentation. Then, log in to your online account to file for reimbursement. Here's how the online or paper claim processing works:

1. **You may pay for the expense,** although it is not necessary to pay the expense prior to submitting your claim for reimbursement. Nevertheless, you are responsible for paying all invoices on time, regardless of when you receive your reimbursement.

2. **If a portion of a health care expense is covered by any insurance for which you are eligible, file a claim under that plan first.** You should receive an explanation of benefits (EOB) or similar statement showing how much the Plan paid, if anything. If you do not receive one, contact the claims administrator or insurance company and request one. You also may submit an itemized print-out from your health plan's website.

3. **Log in to your FSA Account.** Go to *www.connectyourcare.com*. Select the log-in link from the upper right hand corner. If you are a new participant, choose New User Registration to select your username and password. Once logged in, you can easily access your account balance,

enter a new claim and view the reimbursement schedule. Your account balance is available at any time online, or over the phone.

To file a claim online:

a. Log in to your online account and select Claim Center from the main menu across the top of the screen.
b. Click on Add New Claim from the left-hand menu.
c. Follow the four easy steps on the screen to enter information about your claim.
d. Print your cover sheet and then send it by fax or e-mail (as a .tif or .pdf file) with your receipts to the number/email address shown on the form.

If you need help determining which of your expenses are eligible, you should contact ConnectYourCare. Eligibility for reimbursement is based on when services are actually received, regardless of when you pay for such expenses. For further details, see ELIGIBLE EXPENSES under HEALTH CARE REIMBURSEMENT ACCOUNT in this section of the booklet.

4. **Print and mail the completed claim submission form**, along with original invoices and any applicable explanation of benefits (EOBs) or health plan website claims print-outs to:

   ConnectYourCare Processing Center
   307 International Circle, Suite 200
   Hunt Valley, MD 21030

   Be sure to keep a photocopy of everything for yourself before you submit it to the ConnectYourCare processing center. Or you may fax your completed claims submission form and a copy of the original invoices to 1-866-879-0812.

5. **Processing of Claims.** Claims are processed daily. Once your claim is processed, you'll receive a reimbursement check mailed to your home. Or you can sign up for direct deposit into your bank account by signing up at *www.connectyourcare.com*. If you chose automatic bank account deposits for your reimbursement accounts for a calendar year, the election will automatically roll over when you re-enroll in the Plan for a future year.

Reimbursement of Eligible Dependent Care Expenses

You use the money in your reimbursement accounts to "pay" for eligible dependent care expenses as defined by the IRS. When you obtain services that are eligible for reimbursement, you "withdraw" the money from your DCRA.

Pay for out-of-pocket expenses using your own personal credit card, cash or check, and keep your itemized receipt as documentation. Then, log in to your online account to file for reimbursement. You must file all dependent care claims through this process.

Here's how the online or paper claim processing works:

1. **You may pay for the expense,** although it is not necessary to pay the expense prior to submitting your claim for reimbursement. Nevertheless, you are responsible for paying all invoices on time, regardless of when you receive your reimbursement.
2. **Log in to your FSA Account.** Go to *www.connectyourcare.com*. Select the log-in link from the upper right hand corner. If you are a new participant, 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. Your account balance is available at any time online, or over the phone at 1-888-439-5121.

To file a claim online:

a. Log in to your online account and select Claim Center from the main menu across the top of the screen.
b. Click on Add New Claim from the left-hand menu.
c. Follow the four easy steps on the screen to enter information about your claim.
d. Print your cover sheet and then fax or email it (as a tif or pdf file) with your receipts to the number/email address shown on the form.

If you need help determining which of your expenses are eligible, you should contact ConnectYourCare. Eligibility for reimbursement is based on when services are actually received, regardless of when you pay for such expenses. See ELIGIBLE EXPENSES under DEPENDENT CARE REIMBURSEMENT ACCOUNT in this section of this booklet for further details.

3. **Print and mail the completed claim submission form,** along with original invoices to:

   ConnectYourCare Processing Center
   307 International Circle, Suite 200
   Hunt Valley, MD 21030

   Be sure to keep a photocopy of everything for yourself before you submit it to the ConnectYourCare processing center. Or you may fax your completed claims submission form and a copy of the original invoices to 1-866-879-0812.

   Receipts MUST include the following information:

   a. Name of the dependent
   b. Date the service was provided
   c. Name of the service provider
   d. Description of the service
   e. Amount/cost of the item or service provided

   Please note that credit card receipts, non-itemized cash register receipts and cancelled checks are not acceptable forms of documentation.

4. **Processing of Claim.** Claims are processed daily. Once your claim is processed, you'll receive a reimbursement check mailed to your home. Or you can sign up for direct deposit into your bank account by signing up at *www.connectyourcare.com*. If you chose automatic bank account deposits for your reimbursement account for a calendar year, the election will automatically roll over when you re-enroll in the Plan for a future calendar year.

Availability of Annual Contributions for Reimbursement

For the HCRA, the full amount of your annual contribution goal is available immediately to reimburse your claims incurred for the year in which you have participated.

For DCRA claims, the amount of the reimbursement will depend upon how much money is in your account. You will be reimbursed in full for your eligible expenses, provided your account balance is equal to or greater than the amount of your claim. If your account balance is less than the amount of your claim, you will receive partial reimbursement for your claim. The remainder of your claim will be automatically paid during the next processing cycle or after sufficient funds are deposited in your account.

HCRA and DCRA claims are processed daily.

Health Care Reimbursement Account (HCRA)

Eligible Expenses

You can use your Health Care Reimbursement Account (HCRA) to pay for most eligible tax-deductible health care expenses for you and eligible dependents[1] — even if they are not enrolled in a Company-sponsored health care plan. The eligible expenses are defined by the IRS and typically cover most treatments or services used in preventing an illness or improving a medical condition. To be eligible, the service must be received during the period in which you have contributed to HCRA. If you begin contributing mid-year, for example, after certain eligible change-in-status events, expenses incurred before you began contributing are not eligible for reimbursement. Likewise, if you do not continue contributing during an unpaid leave of absence, expenses for health care services received during the leave are not eligible for reimbursement.

Eligible health care expenses are subject to rules set by the IRS (see IRS Section 213d). Eligible expenses include, but are not limited to:

- **Most health care expenses not covered or not paid in full by a health care plan, including any deductibles, copayments, or out-of-pocket expenses for prescription drugs and out-of-network services**
- **Ambulance services**
- **Certain over-the-counter drugs (see OVER-THE-COUNTER DRUGS in this section of the booklet)**
- **Chiropractic care by a licensed chiropractor**
- **Contact lenses**
- **Crutches**
- **Dental Implants**
- **Hearing aids**

The plan document for The Pacific Gas and Electric Company Health Care Reimbursement Account Plan contains the detailed provisions of the Plan and governs the operation of the Health Care Reimbursement Account Plan. If a conflict exists between the Plan document and any other communications or documents, the Plan document shall govern the operation of the Health Care Reimbursement Account Plan.

The Employee Benefit Committee of PG&E Corporation is the Plan Administrator of the Health Care Reimbursement Account Plan and has the discretionary authority to interpret and construe the terms of the Plan, to resolve any conflicts or discrepancies between documents and to establish rules which are necessary or desirable for the administration of the Plan.

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[1] Your eligible dependents are individuals who qualify as dependents under Internal Revenue Code Section 152, as modified by Code Section 105.

- Medical, dental or vision expenses over the Plan maximums or outside the scope of the Plan
- Routine physical exams and vaccinations
- Sterilizations
- Massage with a letter from a physician
  (The letter must cite the specific medical condition being treated and indicate that massage will treat or alleviate it.)
- Laser eye surgery
- Athletic club dues with a letter from a physician
  (The letter must cite the specific medical condition being treated and indicate that athletic activities will treat or alleviate it.)

Ineligible Expenses

Ineligible expenses include, but are not limited to:

- Health care premiums
- Athletic club dues (see ELIGIBLE EXPENSES in this section of the booklet for when charges are allowed)
- Marriage counseling
- Maternity clothes
- Weight-loss programs taken for your general health
- Certain over-the-counter drugs (see OVER-THE-COUNTER DRUGS in this section of the booklet)
- Cosmetic surgery
- Cosmetic dental surgery
- Drugs to stimulate hair growth (e.g., Rogaine)
- Any expense already paid by another one of your health care plans
- Many other expenses not considered a tax-deductible health care expense by the IRS

Over-the-Counter Drugs

Many non-prescription, over-the-counter (OTC) drugs, medicines and medical care items are considered eligible for reimbursement under Health Care Reimbursement Account (HCRA). OTC drugs and items generally fall into one of the following three categories:

1. Those eligible for reimbursement because they are used primarily for medical care.
2. Those ineligible for reimbursement because they are merely beneficial for general health.
3. Those ineligible for reimbursement that become eligible for reimbursement with a letter from the attending physician. The letter must cite the specific medical condition being treated and indicate that the OTC drug or medication will treat or alleviate it.

Reimbursement Accounts
Health Care Reimbursement Account (HCRA)

Eligible for Reimbursement

The following is a sample list of over the counter (OTC) drugs and medical care items that are eligible for reimbursement under the Health Care Reimbursement Account (HCRA). The list does not include all available OTC drugs and medical care items. Please note that the items eligible for reimbursement may change. To determine whether certain expenses, including OTC drugs and medications, are eligible for reimbursement under your HCRA, please contact ConnectYourCare.

Please note: Items marked with PS require a physician's statement to establish eligibility for reimbursement.

ELIGIBLE FOR REIMBURSEMENT	
PRODUCT TYPE	**EXAMPLES INCLUDE, BUT ARE *NOT* LIMITED TO:**
Acne Medications PS pill, liquid, cream, ointment, medicated soaps and cleansing pads	Clean & Clear, Clearasil, Loma Lux Acne, Nature's Cure
Allergy Medicines pill, liquid, nasal spray (also see "Eye Drops")	Benadryl, Chlor-Trimeton, Claritin, Drixoral, NasalCrom, Tavist Allergy
Antacids (anti-gas, lactose intolerance) liquids, pills, tablets	Alka-Seltzer, Beano, Gas-X, Lactaid, Maalox, Mylanta, Pepcid, Pepto-Bismol, Phazyme, Rolaids, Tums
Antibiotic creams/ointments	Bacitracin, Neosporin, Polysporin
Antidiarrheal liquids, pills	Imodium, Kaopectate, Pepto-Bismol
Anti-Fungal Creams & Powders	Aftate, Cruex, Lamisil, Lotrimin, Micatin, Tinactin
Anti-Itch Creams (allergy and poison ivy)	Benadryl, Cortaid, Ivarest, Lanacort
Baby Care Products	Diaper rash cream/ointment, rehydration liquids (Pedialyte, PediaSure), teething gel
Braces and supports	Braces and supports for neck, wrist, ankle, elbow, knee, etc.; support stockings
Canker and Cold Sore Remedies	Abreva, Anbesol, Cankaid, Carmex Kank-A
Cold Medicines	Cough & sore throat lozenges/drops, cough syrup, decongestants, homeopathic cold medicines, nasal sprays, TheraFlu, Tylenol Cold, vapor rubs
Contraceptives/Family Planning	Condoms, contraceptive creams, pregnancy tests, ovulation predictor kits
Diabetic Supplies/Equipment	Alcohol swabs; blood glucose control solutions, monitors, strips and products; lancets and lancet devices, urine testing products
Ear Drops (ear wax removal PS)	Auro Ear Drops, Debrox Ear Drops, Murine Ear Drops
Eye Care Products	Saline and cleaning solutions, eyeglasses, contact lenses

Reimbursement Accounts
Health Care Reimbursement Account (HCRA)

ELIGIBLE FOR REIMBURSEMENT	
PRODUCT TYPE	**EXAMPLES INCLUDE, BUT ARE *NOT* LIMITED TO:**
Eye Drops/Eye Wash Products	Eye wash products to clean out eye or remove foreign objects, Murine, Visine
Feminine Yeast Infection Medicine	Gyne-Lotrimin, Monistat
First Aid	Bandages, dressings, first aid kits, peroxide, rubbing alcohol
Hemorrhoidal Preparations	Preparation H, Tucks
Home Diagnostic Tests or Kits	Cholesterol, colorectal, drug, HIV, ovulation predictor, pregnancy and urine tests; thermometers (ear or standard)
Hot/Cold Packs	ThermaCare
Laxatives (fiber therapy [PS])	Citrucel, Dulcolax, Ex-Lax, FiberCon, Fleet, Metamucil, Milk of Magnesia, Peri-Colace
Lice Treatments	LiceFree, Nix, Pronto, Rid
Motion Sickness Medicine	Bonine, Dramamine, motion sickness wristbands
Pain Relievers	Acetaminophen, Advil, Aleve, Anbesol, Aspercreme, aspirin, aspirin, Ben-Gay, homeopathic pain relievers, ibuprofen, Icy Hot, Midol, Mineral Ice, Motrin, naproxen sodium, pain relieving gels, Tylenol
Pain Relievers – Urinary Tract	Cystex, Uristat
Smoking Cessation Medicine - patches and gum	Nicoderm, Nicorette, Nicotrol, Novartis
Wart or Corn Removers - liquid or pads	Compound W, Curad, Dr. Scholl’s Corn Remover, Wart-Off

Reimbursement Accounts
Health Care Reimbursement Account (HCRA)

Not Eligible for Reimbursement

The following is a sample list of over the counter (OTC) drugs and medical care items that are not eligible for reimbursement under the Health Care Reimbursement Account (HCRA). The list does not include all the non-eligible OTC drugs and medical care items. Please note that items which are not reimbursable may change. To determine whether expenses, including OTC drugs and medications, are eligible for reimbursement under your HCRA, please contact ConnectYourCare.

NOT ELIGIBLE FOR REIMBURSEMENT	
PRODUCT TYPE	**EXAMPLES INCLUDE, BUT ARE *NOT* LIMITED TO:**
Bath Products, Cleansers, Soap	Aveeno, Dial, Dove, Softsoap
Creams, Lip Balm, Lipstick, Lotions, Moisturizers	Basis, Biore, Eucerin, L'Oreal, Neutrogena, Nivea, Noxzema, Oil of Olay, PHisoderm
Dental – Miscellaneous	Breath fresheners; dental floss, adhesives, cleansers, gel, gum, rinses; oral cleaning systems (Water Pik); tongue scrapers; whitening products/systems; toothbrushes; toothpaste
Deodorants/Anti-Perspirants	Ban, Brut, Dry Idea, Speed Stick
Feminine Hygiene	Always, douches, feminine lubricants and pads, tampons
Foot Care Products	Arch and insole supports [PS], Dr. Scholl's callus removers, Odor-Eaters, pedicure products, shoes, toenail clippers
Hair Care Products	Conditioner and shampoo (including those used for dandruff), hairspray, styling aids
Hair Removal Products	Hair-removal creams, razors, wax
Medicine Dispensers	Medicine droppers, pill organizers
Powders	Non-fungus fighting foot powders
Shaving and Grooming Products	Aftershave, razors, shaving cream
Snoring Aids [PS]	Nose drops and strips
Stimulants (to stay awake)	No Doz, Vivarin
Sunscreen, Sunless Tanning, After Sun Products [PS]	Coppertone, Hawaiian Tropic

Partial Prepayments

Many medical treatment programs span several plan years. For example, prenatal care, orthodontia or fertility treatment programs may take two or more years. Reimbursement of the entire expense "up-front" violates the "expense incurred" requirement. In the case of orthodontics, the orthodontist allocates service expenses over the course of the treatment plan. Payments you make for treatment received in the current calendar year are eligible for reimbursement from your account for the same calendar year. Contact ConnectYourCare if you have questions about how claims for ongoing treatment programs will be reimbursed.

Changing Your Annual Contribution Amount

Normally, you may not change the amount you contribute to your Health Care Reimbursement Account or stop payroll deductions mid-year. However, you may be able to increase or decrease your current HCRA annual contribution goal during the year if you have certain eligible change-in-status events. The increase or decrease must be consistent with the change in status. (See MID-YEAR ENROLLMENT CHANGES and CHANGE-IN-STATUS EVENTS under ENROLLMENT in the ABOUT YOUR BENEFITS section of the Handbook.)

Health Care Reimbursement Account Claims and Appeals

Claims

If a Health Care Reimbursement claim you submit is denied in part or whole, ConnectYourCare, as the third-party Claims Administrator, will provide you with written notice within 30 days of their receiving your claim, with an explanation of why the claim was denied and any materials you could submit that would reverse the denial or perfect the claim. In certain cases an additional 15 days may be required by the Claims Administrator to respond to you. If an extension is required, you will be notified of this extension within the initial 30 days from the date when the Claims Administrator received your claim.

Send your appeal to:

ConnectYourCare
Claims Appeals Department
307 International Circle, Suite 200
Hunt Valley, MD 21030

If the Claims Administrator needs additional information from you, you will be given 45 days from the receipt of this notice to provide the additional information. In this case, the Claims Administrator will respond in writing within 15 days after receiving your additional information.

Appeals

If you believe the initial determination denies you a Health Care Reimbursement Account benefit to which you may be entitled, you may appeal to the Plan Administrator.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
Plan Administrator Appeals
1850 Gateway Blvd., 7th Floor
Concord, CA 94520

This appeal must be made in writing within 180 days of the initial determination of the amount that has been paid to you and must contain the following information:

- The reason(s) for making the appeal;
- The facts supporting the appeal;
- The amount claimed; and

Reimbursement Accounts
Health Care Reimbursement Account (HCRA)

- The name and address of the person filing the appeal (claimant).

To expedite processing, you should also include a HIPAA AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION form. You can access a copy online from the **Plans, Policies & Forms > Human Resources Forms** section of the PG&E HR intranet site or by calling the HR Service Center at 415-973-HELP (415-973-4357) or toll-free at 1-800-788-2363.

The Benefits Department will generally make a decision within 30 days after receiving the appeal and mail a copy of the decision to you promptly. The decision will give specific reasons and references to the Health Care Reimbursement Account Plan provisions which support the Benefits Department's decision.

If you are not satisfied by the findings of the Benefits Department, you may formally appeal in writing to the Employee Benefit Appeals Committee. You have 90 days from the date on which you receive a decision from the Benefits Department to formally submit your appeal. You should include all relevant information in your appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
1850 Gateway Blvd., 7th Floor
Concord, CA 94520

You shall receive EBAC's decision within 30 days of EBAC's receipt of the appeal unless special circumstances require an extension for processing the appeal. If special circumstances exist, EBAC may take up to an additional 30 days provided you are notified of the extension in writing within the initial 30 day period.

If the EBAC denies your appeal, you will receive a written response that will include:

- the specific reason(s) for the denial of the claim;
- reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- A statement of your right to bring a civil action under section 502(a) of ERISA.

Dependent Care Reimbursement Account (DCRA)

Whose Expenses May Be Reimbursed?

The definition of a DCRA Dependent may differ from the one used in determining your personal income taxes and from the definition used to determine whose expenses may be reimbursed from your Health Care Reimbursement Account.

The following table lays out the requirements for the three types of DCRA Dependents. To be considered a Dependent for DCRA purposes, the person receiving care must satisfy all of the requirements listed in any one of the columns: A or B or C. If the person does NOT satisfy all the requirements in one of the columns, he or she is not an eligible DCRA Dependent, and you may not be reimbursed for his or her expenses.

The three categories of DCRA Dependents are:

- Column A: your children and other relatives. Most people use the DCRA for daycare expenses of their children. If your child is less than 13 years old, lives with you for more than half the year, and is supported by you, he or she is probably your DCRA Dependent. These requirements are listed in Column A.
- Column B: your disabled relatives. Children older than 13 and other relatives who are incapable of self-care often require care while you work. These requirements are listed in Column B.
- Column C: disabled non-relatives. If you support a non-relative who is incapable of self-care, he or she may be considered your DCRA Dependent. See Column C for these requirements.

The plan document for The Pacific Gas and Electric Company Dependent Care Reimbursement Account Plan contains the detailed provisions of the Plan and governs the operation of the Plan. If a conflict exists between the Plan document and any other communications or documents, the Plan document shall govern the operation of the Dependent Care Reimbursement Account Plan.

The Employee Benefit Committee of PG&E Corporation is the Plan Administrator of the Dependent Care Reimbursement Account Plan and has the discretionary authority to interpret and construe the terms of the Plan, to resolve any conflicts or discrepancies between documents and to establish rules which are necessary or desirable for the administration of the Plan.

Reimbursement Accounts
Dependent Care Reimbursement Account (DCRA)

The information on the table is intended to provide a summary only. It does not represent legal or tax advice. Consult with your own legal and tax advisors to assure compliance with applicable law.

<table>
<tr><th rowspan="2">REQUIREMENTS</th><th>A</th><th>B</th><th>C</th></tr>
<tr><th>IF THE PERSON SATISFIES EVERY REQUIREMENT IN THIS COLUMN, HE OR SHE IS A DCRA DEPENDENT.
IF THE PERSON FAILS ANY ONE OR MORE OF THESE REQUIREMENTS, TRY COLUMN B OR C.</th><th>IF THE PERSON SATISFIES EVERY REQUIREMENT IN THIS COLUMN, HE OR SHE IS A DCRA DEPENDENT.
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IF THE PERSON FAILS ANY ONE OR MORE OF THESE REQUIREMENTS, TRY COLUMN A OR B.</th></tr>
<tr><td>RELATIONSHIP REQUIREMENT</td><td>Dependent must be one of the following:
• Son, daughter
• Stepson, stepdaughter
• Descendant of a son, daughter, stepson or stepdaughter
• Brother, sister
• Descendant of a brother or sister
• Stepbrother, stepsister
• Descendant of a stepbrother or stepsister</td><td>Dependent must be one of the following:
• Son, daughter
• Stepson, stepdaughter
• Descendant of a son, daughter, stepson or stepdaughter
• Brother, sister
• Descendant of a brother or sister
• Stepbrother, stepsister
• Descendant of a stepbrother or stepsister
• Father, mother
• Brother or sister of father or mother
• Ancestor of father or mother
• Stepfather or stepmother
• Son-in-law, daughter-in-law
• Father-in-law, mother-in-law
• Brother-in-law, sister-in-law</td><td>None

Dependent is not required to be related to you under Column C.</td></tr>
<tr><td>RESIDENCY REQUIREMENT</td><td>You and Dependent must have the same primary residence for more than half the year</td><td>You and Dependent must have the same primary residence for more than half the year</td><td>You and Dependent must have the same primary residence for the entire year</td></tr>
<tr><td>SUPPORT REQUIREMENT</td><td>Dependent may not provide more than half of his or her own support</td><td>You must provide more than half the Dependent’s support</td><td>You must provide more than half the Dependent’s support</td></tr>
</table>

Reimbursement Accounts
Dependent Care Reimbursement Account (DCRA)

REQUIREMENTS	A	B	C
	IF THE PERSON SATISFIES EVERY REQUIREMENT IN THIS COLUMN, HE OR SHE IS A DCRA DEPENDENT. **IF THE PERSON FAILS ANY ONE OR MORE OF THESE REQUIREMENTS, TRY COLUMN B OR C.**	**IF THE PERSON SATISFIES EVERY REQUIREMENT IN THIS COLUMN, HE OR SHE IS A DCRA DEPENDENT.** **IF THE PERSON FAILS ANY ONE OR MORE OF THESE REQUIREMENTS, TRY COLUMN A OR C.**	**IF THE PERSON SATISFIES EVERY REQUIREMENT IN THIS COLUMN, HE OR SHE IS A DCRA DEPENDENT.** **IF THE PERSON FAILS ANY ONE OR MORE OF THESE REQUIREMENTS, TRY COLUMN A OR B.**
AGE AND DISABILITY REQUIREMENT	Dependent must be less than 13 years old OR Dependent must be physically or mentally incapable of self-care (“disabled”) and under age • 19 or • 24 if a full-time student	Dependent must be physically or mentally incapable of self-care (“disabled”)	Dependent must be physically or mentally incapable of self-care (“disabled”)
LEGAL STATUS REQUIREMENTS	Dependent must be one of the following: • U.S. Citizen • U.S. Resident • Mexican or Canadian resident		

Eligible Expenses

You can use your DCRA to pay for eligible day care expenses on a tax-free basis if you are a single parent or if both you and your spouse work.

To qualify as an eligible expense, day care for your DCRA Dependents must be necessary for you to continue working. If you are married, both spouses must be actively at work or attending school (unless one of you is disabled) for a DCRA expense to be valid. If one spouse is at home (e.g., on maternity leave), expenses incurred for day care are not eligible expenses. Refer to the *IRS Publication 503*, *Child and Dependent Care Expenses,* available from your local IRS office (or the IRS website at www.irs.gov), or consult with a tax advisor for more details on allowable expenses. In addition, day care expenses must not exceed your earned income, or if you are married, your spouse’s salary.

To be eligible, the expenses must be incurred during the period in which you actually made the contributions to your DCRA. If you begin contributing mid-year, expenses incurred before you began contributing are not eligible.

Eligible dependent care expenses as defined by the IRS include:

- **Child care for dependents under age 13**
- **In-home nursing or other custodial care for elderly or other dependents over age 13 who are living with you and who are physically or mentally unable to care for themselves**
- **Care provided by someone other than a family member**

- Care provided by a licensed individual or center meeting criteria set by federal and state laws
- Services provided outside your home, such as at an adult or child day care center or nursery school

Ineligible Expenses

The IRS **does not** allow charges for the following:

- Expenses for an individual that does not meet the requirements outlined under WHOSE EXPENSES MAY BE REIMBURSED FROM A DCRA?
- Expenses incurred for day care services received while you or your spouse are on a leave of absence
- Education programs
- Sports Camps and Overnight Camps with the exception of summer day camp if a child is not in school and the camp is used as day care

Please note that this is only a sampling of eligible and ineligible expenses. You should refer to *IRS Publication 503*, *Child and Dependent Care Expenses,* available from your local IRS office (or the IRS website at www.irs.gov), or consult with a tax advisor for more details on allowable expenses.

Changing Your Annual Contribution Amount

You may make a change in the annual amount you contribute only if you have a change-in-status event (such as the birth or adoption of a child), and your change in contributions is consistent with the status change. See CHANGE-IN-STATUS EVENTS and OTHER CHANGES INVOLVING A DOMESTIC PARTNERSHIP OR SAME-SEX MARRIAGE under ENROLLMENT in the ABOUT YOUR BENEFITS section of the Handbook. You may also make a corresponding change to your DCRA if you replace one dependent care provider with another or if there is a change in the cost for the services of *a caregiver who is not a relative*. However, the IRS will not allow a mid-year change to your DCRA for a change in the fee charged by a relative. For example, if your child's day care center increases its fees, a change in your Dependent Care Reimbursement Account would be allowed. Or if you want to change from using a day care center to employing an aunt to watch your child, an election change would be permitted even though the aunt is related to you. If later, however, you decide to give your aunt a raise, you may not make a mid-year election change to reflect the raise. Please remember, your DCRA may be cancelled only under certain circumstances (for example, if you switch from a child care facility to a relative or friend who will not charge you for the services provided).

Tax Credits

The Dependent Care Reimbursement Account is one way to reduce your tax liability if you pay dependent care expenses. The Federal Dependent Care Income Tax Credit also helps you lower your income tax liability. Here is some information on how the two methods work:

- Every dollar you contribute to a DCRA through payroll deductions reduces, dollar-for-dollar, your taxable income, which is the basis for determining the amount of income tax you owe. A

one dollar reduction of your taxable income will generally reduce the income tax you owe by less than one dollar.

- The Federal Dependent Care Income Tax Credit directly reduces the amount of income tax you owe dollar-for-dollar. However, the amount of the tax credit you may claim is only a fraction of your dependent care expenses, the fraction varying with your total income.
- You may use both the DCRA and the Federal Dependent Care Income Tax Credit, but not for the same expenses. In other words, if you open a DCRA, you may only take the Federal Dependent Care Income Tax Credit for expenses not reimbursed through your account. Or if you plan to take the tax credit, you may only use your DCRA to pay for expenses not used in figuring your tax credit.
- Every dollar that you contribute to the DCRA reduces, dollar-for-dollar, the dollar limitation on the amount of expenses eligible to calculate the Federal Dependent Care Income Tax Credit that you may claim on your income tax return.

As tax savings of the DCRA and the Tax Credit vary with the number of your dependents, the amount of your dependent care expenses, and your marginal tax rate, it is best to check with your tax advisor to determine which method or combination offers the greatest tax savings for your particular situation. You may also refer to IRS Publication No. 503 (Child and Dependent Care Expenses).

Dependent Care Reimbursement Account Claims and Appeals

Claims

If a Dependent Care Reimbursement claim you submit is denied in part or whole, ConnectYourCare, as the third-party Claims Administrator, will notify you within 60 days of their receiving your claim, with an explanation of why the claim was denied and any materials you could submit that would reverse the denial or perfect the claim.

Send your appeal to:

ConnectYourCare
Claims Appeals Department
307 International Circle, Suite 200
Hunt Valley, MD 21030

Appeals

If you believe the initial determination denies you a benefit to which you may be entitled, you may appeal to the Plan Administrator.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
Plan Administrator Appeals
1850 Gateway Blvd., 7th Floor
Concord, CA 94520

Reimbursement Accounts
Dependent Care Reimbursement Account (DCRA)

This appeal must be made in writing within 90 days of the initial determination and must contain the following information:

- The reason(s) for making the appeal;
- The facts supporting the appeal;
- The amount claimed; and
- The name and address of the person filing the appeal (claimant).

The Benefits Department will generally make a decision within 60 days after receiving the appeal and must mail a copy of the decision to you promptly. The decision will give specific reasons and references to the Dependent Care Reimbursement Account Plan provisions which support the Benefit Department's decision.

If you are not satisfied by the findings of the Benefits Department, you may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). Appeals to EBAC must be received within 90 days of your receipt of a denial by the Benefits Department. You must submit a new appeal in writing stating the reason(s) for your appeal and enclosing all relevant documentation and information that support your appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
1850 Gateway Blvd., 7th Floor
Concord, CA 94520

You shall receive EBAC's decision within 30 days of EBAC's receipt of the appeal unless special circumstances require an extension for processing the appeal. If special circumstances exist, EBAC may take up to an additional 30 days provided you are notified of the extension in writing within the initial 30 day period.

If the EBAC denies your appeal, you will receive a written response that will include:

- the specific reason(s) for the denial of the claim;
- reference to the specific Plan provision(s) on which the denial is based; and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

More About Reimbursement Accounts

Reimbursement Account Limitations

Reimbursement accounts are governed by IRS regulations. When you are deciding on the amounts you want to allocate to each account, you should keep in mind these regulations and limitations:

- Once you have decided on your annual contribution amount, you cannot change the amount you contribute during the year unless you have an eligible change-in-status event through marriage[1], divorce[1], termination of a domestic partnership if the domestic partner was a tax dependent, death of a spouse/tax dependent registered domestic partner or child, birth or adoption of a child, a gain or loss of your spouse's/tax dependent registered domestic partner's employment, a change in employment status by you or your spouse/tax dependent registered domestic partner, a change of caregivers or a change in the cost for the services of a caregiver who is not a relative, or certain other losses of coverage.

  If you experience one of the change-in-status events, you may change your contribution amount by contacting the HR Service Center within 31 days of the status change (60 days for births or adoptions). Your change in contributions must be consistent with your change in status. For example, if you add a new dependent, you may increase, but not decrease, your annual Health Care Reimbursement Account goal. See MID-YEAR ENROLLMENT Changes and CHANGE-IN-STATUS EVENTS under ENROLLMENT in the ABOUT YOUR BENEFITS section of the Handbook.

- If you have both a Health Care Reimbursement Account and a Dependent Care Reimbursement Account, you cannot transfer money between your two accounts.

- All of the money in your accounts must be used to pay for services received during the period for which it was allocated. Any money left in a Reimbursement Account after all expenses for the Plan Year have been submitted is, under tax law, forfeited. You cannot carry unused money forward into the next year. The only exception is for reimbursable health related expenses incurred during the HCRA Grace Period. See GRACE PERIOD (FOR HEALTH CARE REIMBURSEMENT ACCOUNTS) under MORE ABOUT REIMBURSEMENT ACCOUNTS – DEADLINE FOR CLAIM REIMBURSEMENTS.

  The forfeiture of unused dollars is the reason why it is imperative that you estimate your costs carefully before deciding on your Reimbursement Account contributions.

Deadline for Claim Reimbursements

Reimbursements for eligible expenses incurred through December 31 can be submitted to the processing center up until March 31 of the following year, provided funds have not already been

[1] The marriage or divorce of same-sex spouses is not a change-in-status event unless the same-sex spouse is a tax dependent. See CHANGE-IN-STATUS EVENTS and OTHER CHANGES INVOLVING A DOMESTIC PARTNERSHIP OR SAME-SEX MARRIAGE under ENROLLMENT in the ABOUT YOUR BENEFITS section of the Handbook.

exhausted. **In accordance with IRS restrictions, any money remaining in the account after March 31 will be forfeited unless you are eligible to take advantage of the Grace Period for HCRA eligible expenses.**

Grace Period (for Health Care Reimbursement Accounts)

The Health Care Reimbursement Account has a 2½-month Grace Period for the payment of reimbursable expenses. This means you have the 2½-month period immediately following the calendar year to use-up any unused amounts remaining in your HCRA Account at the end of each Plan Year. The Grace Period is only available if you are a:

- Participant in the HCRA with an active HCRA Account on the last day of the Plan Year (i.e., December 31); or
- Qualified beneficiary with an active HCRA Account through COBRA continuation on the last day of the Plan Year (i.e., December 31).

Any expenses incurred during the Grace Period must qualify as an eligible expense. (See ELIGIBLE EXPENSES under HEALTH CARE REIMBURSEMENT ACCOUNT in this section.) Eligible expenses incurred during the Grace Period will first be applied to the HCRA Account balance from the prior year and then to the HCRA Account balance for the current year.

If you incur expenses that are eligible for reimbursement under the 2008 Plan Year Grace Period (January 1 thru March 15, 2009), you will need to submit the claim to Ceridian. Beginning January 1, 2009, ConnectYourCare is the Claims Administrator. See CLAIMS ADMINISTRATOR under SUMMARY in this section of the Handbook.

Examples:

Assume you have $300 that was not used during 2008 and you elect to contribute $750 during 2009. You incur reimbursable expenses during January 2009 in the amount of $400. Reimbursement of $300 will be from your 2008 HCRA Account balance and the remaining $100 will be from your 2009 HCRA Account.

Assume the same example but you do not incur a reimbursable expense until April 2009. In this situation, reimbursement will only be made from your 2009 HCRA account. Your 2008 HCRA account balance cannot be used and it is forfeited. See REIMBURSEMENT ACCOUNT LIMITATIONS in this section.

If You Take a Leave of Absence Without Pay

Health Care Reimbursement Account (HCRA)

Your before-tax contributions from your paycheck will stop while you are on an unpaid leave. You will, however, have the option of continuing the same monthly contribution amount on an after-tax basis during your leave, or you may cancel your HCRA. Whether you elect to continue or cancel your contributions, you must complete a Health Care Reimbursement Account (HCRA) Election While on Unpaid Leave of Absence form and return it to the Benefits Service Center within 15 days of receipt.

During the First Calendar Year of Your Leave

If you elect to continue your contributions on an after-tax basis while on your leave, you will be billed each month through the end of the current plan year. Expenses for services received during your leave will be eligible for reimbursement. If you return to work in the same year as the one in which your leave began, the same monthly before-tax contributions will resume, unless you elect to change this amount due to an eligible change-in-status event.

Your Health Care Reimbursement Account will be canceled for non-payment if payment is not received within 30 days. Should this occur, expenses incurred in the months in which payment is not received will not be eligible for reimbursement.

If you elect to cancel your contributions while on your leave, expenses for services received during your leave will not be eligible for reimbursement. If you wish to reinstate before-tax contributions upon your return to work in the same year as the one in which your leave began, you must contact the HR Service Center within 31 days of your return to work. You may choose one of the following options upon your return to work:

- You may elect to reinstate your original monthly amount, which will have the effect of reducing your original goal. For example: If you elected $1,200 for the year ($100 per month) and you were on a leave of absence for three months, when you reinstate your Health Care Reimbursement Account, you would begin making the same monthly contribution of $100; however, you would only have $900 available to you for reimbursement if you had not incurred any expenses prior to your leave ($1,200 – $300 = $900).
- You may choose to reinstate your original annual goal. If you elect this option, your monthly contribution amount will be prorated for the remainder of the year. For example: If you elected $1,200 for the year and went on leave April 1 for three months, the first three months' contributions would be at $100 per month and the remaining six months after returning from leave July 1 would be at $150 per month, for a total of:
  $1,200 (3 X $100 = $300, plus 6 X $150 = $900; $300 plus $900 = $1,200).

If you do not contact the HR Service Center within 31 days of your return to work, you may not elect to contribute to a Health Care Reimbursement Account until the next Open Enrollment period, unless you have an eligible change in status.

During the Second Calendar Year of Your Leave

If your leave of absence extends into the following calendar year and you want to make contributions during the following year, you must make your election during the Open Enrollment period that precedes the beginning of the new calendar year. The elections you make during Open Enrollment will determine your HCRA contributions while on leave during the new calendar year.

- If you elected to contribute to a HCRA during Open Enrollment, you will be sent an election form on which you must indicate whether or not you wish to contribute to your HCRA on an after-tax basis at the beginning of the new year.
- If you elect to contribute on an after-tax basis once the new year begins, you will be billed for your HCRA contributions on a monthly basis, and expenses for eligible services received while on leave will be eligible for reimbursement. When you return to work later in the year, the same monthly contributions will be continued via payroll deduction on a before-tax basis. Your Health Care Reimbursement Account will be canceled for non-payment if payment is not

received within 30 days. Should this occur, expenses incurred in the months in which payment is not received will not be eligible for reimbursement.

- If you decline to contribute on an after-tax basis when the new year begins, expenses for eligible services received while on leave will not be eligible for reimbursement. If you wish to contribute to a HCRA upon your return from leave later in the year, you must contact the HR Service Center within 31 days of your return to work.

Dependent Care Reimbursement Account (DCRA)

Your before-tax salary contributions and participation will stop while you are on an unpaid leave. However, you may continue to submit claims for eligible expenses incurred while you were participating in the Dependent Care Reimbursement Account (DCRA) until your balance is exhausted. The same monthly contributions will automatically resume the month following your return to work—provided you return in the same year as the one in which your leave began—unless you changed your monthly contributions due to an eligible change-in-status event.

Change-in-Status Events While on Leave

If you have a change-in-status event while on an unpaid leave, you may elect to change the amount of contributions to your reimbursement account(s), provided the change is consistent with your change in status, by contacting the HR Service Center within 31 days of the change.

When recalculating your new contribution goal, you should calculate your monthly contributions based on the number of months remaining in the year after you return to work.

If You Are on Long-Term Disability or Workers' Compensation

If you are on long-term disability (LTD), during the annual Open Enrollment period you may not elect to contribute to HCRA or DCRA. If you are on Workers' Compensation, during the annual Open Enrollment period you may not elect to contribute to a HCRA unless you are also on an FMLA leave (see LEAVES OF ABSENCE in the TIME OFF section of the Handbook for a description of FMLA leaves) and you may not contribute to DCRA. To continue your HCRA contributions while on Workers' Compensation, you must contact the HR Service Center at 415-973-HELP (415-973-4357) or toll-free at 1-800-788-2363.

If You Retire or Leave the Company

Monthly contributions to the DCRA will stop at the earlier of the end of the month in which you leave the Company, die or the end of the month prior to your retirement.

You may continue your HCRA contributions until the end of the current year on an **after-tax** basis if participation is continued through COBRA (see the COBRA AND CONVERSION TO AN INDIVIDUAL MEDICAL POLICY section of the Handbook). However, if participation is not continued through COBRA, contributions will stop at the earlier of the end of the month in which you leave the Company or the end of the month prior to your retirement. You may not contribute to a HCRA through COBRA in the year following your termination or retirement. However, if you elect COBRA and are a Qualified Beneficiary on December 31, you may submit claims for expenses incurred during the HCRA Grace Period.

Reimbursement Accounts
More About Reimbursement Accounts

You can submit claims for reimbursement from either account for eligible expenses for services received during the months you were employed by the Company and made contributions to your account. Claims can be submitted to the processing center until March 31 of the following year. In accordance with IRS regulations, any money remaining in the account after March 31 will be forfeited.

For more information, please contact the HR Service Center at 415-973-HELP (415-973-4357) or toll-free at 1-800-788-2363.

Questions About Claims for Reimbursement

You should refer any questions about your claims for reimbursement to ConnectYourCare, the Claims Administrator, at the following address and/or call 1-888-439-5121.

ConnectYourCare
Claims/Customer Service
307 International Circle, Suite 200
Hunt Valley, MD 21030

ERISA Information

Summary

As a participant in the Health Care Reimbursement Account described in this booklet, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). The Pacific Gas and Electric Company Dependent Care Reimbursement Account is not a welfare plan under ERISA and therefore the information included under this ERISA Information topic does not apply to the Dependent Care Reimbursement Account.

Your Rights Under ERISA

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining unit agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. You may also review all official plan documents, during normal business hours, in the Benefits Department.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care reimbursement account coverage for yourself, spouse/domestic partner or dependents if there is a loss of coverage under the Plan as a result of a qualifying event under COBRA. You or your dependents may have to pay for such coverage. You may also review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if it finds your claim is frivolous.

Assistance with Your Questions

If you have questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Administrative Information About the Plan

NAME AND ADDRESS OF EMPLOYER	The Pacific Gas and Electric Company Health Care Reimbursement Account Plan is sponsored by: Pacific Gas and Electric Company Benefits Department 1850 Gateway Boulevard, 7th Floor Concord, CA 94520
EMPLOYER IDENTIFICATION NUMBER	The Internal Revenue Service has assigned this ID number to the Plan sponsor: Pacific Gas and Electric Company: 94-0742640

Reimbursement Accounts
ERISA Information

PARTICIPATING EMPLOYERS	The Pacific Gas and Electric Company PG&E Corporation PG&E Corporation Support Services, Inc. PG&E Corporation Support Services II, Inc.
PLAN NAME:	The Pacific Gas and Electric Company Health Care Reimbursement Account Plan
PLAN NUMBER:	526 (Health Care Reimbursement Account Plan only)
PLAN TYPE	Health Care Expense Reimbursement
PLAN YEAR	1/1 – 12/31
PLAN ADMINISTRATORS	The Plan Administrators for the Plan is: The Employee Benefit Committee (EBC) of PG&E Corporation c/o Pacific Gas and Electric Company Benefits Department 1850 Gateway Boulevard, 7th Floor Concord, CA 94520
PLAN TRUSTEE, INSURANCE ISSUER AND/OR THIRD PARTY ADMINISTRATOR	Third Party Claims Administrator for the Health Care Reimbursement Account Plan and the Dependent Care Reimbursement Account Plan: ConnectYourCare Claims/Customer Service 307 International Circle, Suite 200 Hunt Valley, MD 21030
DISCRETIONARY AUTHORITY	The Plan Administrator has the oversight responsibility for the administration of the Plan which includes maintaining records, and making rules, computations, interpretations and decisions that may be necessary for administration of the Plans. The Plan Administrator has the discretionary authority to interpret, construe, and define the terms of the Plan.

Reimbursement Accounts
ERISA Information

AGENT FOR THE SERVICE OF LEGAL PROCESS	If you wish to take legal action after exhausting the applicable claims and appeals procedures, a lawsuit may be served on the ERISA Plan Administrator. Service should be directed to: Linda Y.H. Cheng Vice President, Corporate Governance and Corporate Secretary Pacific Gas and Electric Company One Market, Spear Tower Suite 2400 San Francisco, CA 94105
OTHER ADMINISTRATIVE INFORMATION	ERISA divides employee benefit plans into two broad categories: welfare plans and pension plans. Your Pacific Gas and Electric Company Health Care Reimbursement Account Plan is a "welfare" plan.
FUNDING	The Pacific Gas and Electric Company Health Care Reimbursement Account Plan: The administrative expenses are paid by the Company from general assets and at the Company's discretion by application of forfeited account balances. The Pacific Gas and Electric Company Dependent Care Reimbursement Account Plan: The administrative expenses are paid by the Company from general assets and at the Company's discretion by application of forfeited account balances.

Plan Amendment and Termination

The Company, acting through its authorized representatives, reserves the right to amend or terminate the Plan at any time and for any reason, or suspend contributions to the Plan, in whole or in part, at any time, subject to notice provisions if such notice is required under applicable collective bargaining agreements.

Any change or termination to either the Pacific Gas and Electric Company Health Care Reimbursement Account Plan or the Pacific Gas and Electric Dependent Care Reimbursement Account Plan will not affect the benefits payable to plan members before the date the Plan was changed or ended, but such change may result in reduced levels of benefits or benefit coverage, or higher levels of employee contributions, after the effective date of any such change.

In the event that the Company terminates the Plans for any reason without replacing it, you will be given notice. The Plan may be terminated by judicial action if the Company is bankrupt or insolvent, or upon complete dissolution, merger, consolidation or reorganization without provision by a successor-company for continuation of the Plan.

COBRA Premium Reduction Provisions

Summary of Material Modification

This Summary of the COBRA Premium Reduction Provisions section of the booklet constitutes a Summary of Material Modifications (SMM) to the Pacific Gas and Electric Company Health Care Plan for Active Employees (the Plan), effective March 2009.

In addition to being a Summary of Material Modifications, this Summary of the COBRA Premium Reduction Provisions under ARRA section of the booklet supplements the information contained in Section C – COBRA AND CONVERSION TO AN INDIVIDUAL MEDICAL POLICY of the Summary of Benefits Handbook for Employees Represented by the IBEW, ESC or SEIU ("Handbook"). Unless otherwise noted, when reference is made to a different topic or section, the reference is to the Handbook, not this booklet.

Pacific Gas and Electric Company has the right to amend or terminate the Plan 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 Plan will apply prospectively and will affect your rights and obligations under the Plan prospectively.

Summary of Benefits

This section contains important information about your right to continue your health care coverage in the Pacific Gas and Electric Company Health Care Plan for Active Employees (the Plan). Please read the information contained in this section very carefully.

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009, and can last up to nine months.

Eligibility

To be considered an "Assistance Eligible Individual" and get reduced premiums you:

- MUST be eligible for COBRA coverage at any time during the period from September 1, 2008, through December 31, 2009, and elect the coverage;
- MUST have a COBRA coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008, through December 31, 2009;
- MUST NOT be eligible for Medicare; AND

- **MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a spouse's employer or the Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents.*[*]***

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008, through February 16, 2009, and were offered, but did not elect, COBRA coverage OR who elected COBRA coverage and subsequently discontinued it may have the right to an additional 60-day election period.

♦ IMPORTANT ♦

- **If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare, you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.**
- **Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.**
- **The amount of the premium reduction is recaptured for certain high-income individuals. If the amount you earn for the year is more than $125,000 (or $250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at *www.irs.gov*.**

Additional Information

For general and specific information regarding your plan's COBRA coverage, please visit Ceridian's website at *www.ceridian-benefits.com*, or contact the COBRA Services Center by mail at 3201 34th Street South, St. Petersburg, FL 33711. For quick access to information, go to *www.ceridian-benefits.com.* You may also call 1-800-977-7994.

To notify Ceridian of your ineligibility to continue paying reduced premiums, mail the Notification of Ineligibility of Premium Reduction form to: Ceridian COBRA Continuation Services, Attn: COBRA Benefits Administration, 3201 34th Street South, St. Petersburg, FL 33711. The form is available to participants when they become eligible for the COBRA premium reduction provisions under ARRA, and is also available on *www.ceridian-benefits.com*.

If you are denied treatment as an "Assistance Eligible Individual," you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction, go to *www.dol.gov/COBRA* or call 1-866-444-EBSA (3272).

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[*] Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

HIPAA Special Enrollment Period

Summary of Material Modifications

This HIPAA Special Enrollment Period section of the booklet constitutes a Summary of Material Modifications (SMM) to the Pacific Gas and Electric Company Before-tax Plan for Union-Represented Employees ("Plan"), effective April 2009.

In addition to being a Summary of Material Modifications, this HIPAA Special Enrollment Period section of the booklet replaces the HIPAA SPECIAL ENROLLMENT PERIOD and LOSS OF OTHER COVERAGE provisions on page B-I-10 of the Summary of Benefits Handbook for Employees Represented by the IBEW, ESC or SEIU ("Handbook"). Unless otherwise noted, when reference is made to a different topic or section, the reference is to the Handbook, not this booklet.

Pacific Gas and Electric Company has the right to amend or terminate the Plan 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 Plan will apply prospectively and will affect your rights and obligations under the Plan prospectively.

HIPAA Special Enrollment Period

A HIPAA Special Enrollment Period may be available to you and your Eligible Dependents if you declined coverage under a Company-sponsored health care plan (medical, dental or vision) because you had other coverage and:

- you lose eligibility for the other coverage (or if the employer stops contributing towards the other coverage), or
- you have a newly Eligible Dependent due to marriage, establishment of a domestic partnership, birth, adoption or placement for adoption, or

Effective April 1, 2009

- you or your dependent loses eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage, or
- you or your dependent becomes eligible for a state's premium assistance program under Medicaid or CHIP.

You must request enrollment by contacting the HR Service Center within 31 days of the date of your marriage or domestic partnership registration, within 60 days of the birth, adoption or placement for adoption of a child, and within 60 days of the date of the Medicaid/CHIP eligibility change.

Loss of Other Coverage Provision

The conditions making you eligible for a HIPAA Special Enrollment Period due to loss of other coverage are:

- Loss of eligibility under the other health coverage because:
  - of a legal separation (but only if it causes a loss of coverage);
  - of a divorce, death, termination of employment or reduction in hours;
  - dependent no longer meets eligibility requirements due to age or for other reasons;
  - you, or your Eligible Dependent Children, are covered by an HMO through your spouse's employer and you no longer reside in the HMO service area and have no other available plan option; or
  - the plan no longer offers benefits to similarly situated individuals.
- Termination of employer contributions under the other health care plan.
- The other health care coverage was through COBRA, and you have exhausted COBRA coverage.
- You meet or exceed a lifetime limit on all benefits under another health plan.

If you are eligible for a HIPAA Special Enrollment Period due to the loss of other coverage, you are eligible to elect coverage for yourself and your Eligible Dependent(s) in a medical plan, the Dental Plan, and/or the Vision Plan within 31 days from the date of the loss of other coverage. Coverage resulting from this HIPAA Special Enrollment period will be effective on the first day of the month following receipt of your enrollment. If you do not enroll within the 31-day enrollment period, you will not be covered under the Company medical, dental and vision plans and you must wait until the next Open Enrollment period to enroll.

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Retirement Income Plans

Summary of Material Modifications

This Retirement Income Plans section of the booklet constitutes a Summary of Material Modifications to the Pacific Gas and Electric Company Retirement Plan (Plan), effective January 1, 2009.

In addition to being a Summary of Material Modifications, this Retirement Income Plans section of the booklet completely replaces Section H of the Summary of Benefits Handbook for Employees Represented by IBEW, ESC or SEIU ("Handbook"). Unless otherwise noted, when you are referred to information in a different topic or section, the reference is to the Handbook, not this booklet.

Pacific Gas and Electric Company has the right to amend or terminate the Plan 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 Plan will apply prospectively and will affect your rights and obligations under the Plan prospectively.

Summary of Benefits

The Company[1] offers two benefit plans that help you plan and save for your financial security after your retirement:

- The Pacific Gas and Electric Company Retirement Plan
- The PG&E Corporation Retirement Savings Plan for Union-Represented Employees

The Retirement Plan is a "defined benefit" plan, which means eligible participants receive a fixed monthly pension benefit that is based on a defined formula. A detailed summary description of the PG&E Retirement Plan is included in this section.

The Retirement Savings Plan, sometimes referred to as the 401(k) plan, is a "defined contribution" plan, which means eligible participants receive a benefit based on contributions made to the Plan. A participant's benefit varies with the amount of personal and Company contributions made to the Plan as well as investment gains and losses on these contributions. Summary information about this Retirement Savings Plan (RSP) is provided in a separate Summary Plan Description (SPD): The PG&E Corporation Retirement Savings Plan for Union Represented Employees.

The Company also makes contributions based on your pay towards your future Social Security retirement benefits. These contributions are in addition to the deductions for social security taxes taken out of your paycheck.

[1] Throughout this section of the booklet, reference to "Company" means Pacific Gas and Electric Company.

Retirement Income Plans

You should plan carefully for your financial security after you retire. In addition to Social Security and the two retirement income plans available through the Company, your individual savings are a vital component in ensuring the lifestyle you desire when you retire. You may want to consult with a financial planner to develop an individual savings plan that is most appropriate for your future needs.

Retirement Plan

Summary

Pacific Gas and Electric Company's Retirement Plan provides eligible participants with a fixed monthly benefit that offers a source of steady income during retirement. It's important for you to understand how the Plan works and what kind of income you can expect from it so that you can begin planning for your retirement now. Your own savings, plus the benefits available to you from the Retirement Plan and Social Security, all contribute to your future financial status.

Ready to Retire?

You must request a Retirement Package in writing at least 90 days before the date on which you want to retire. Your completed paperwork must be received by the HR Service Center at least 30 days prior to your retirement date. If you have questions about initiating your retirement request, you can send an e-mail to the HR Service Center at *HRBenefitsQuestions@exchange.pge.com*, or you can contact the HR Service Center at 415-973-HELP (415-973-4357) or toll-free at 1-800-788-2363. See PAYMENT OPTIONS in this section of the booklet for more information.

Be sure to notify your supervisor of your retirement so your last paycheck will be processed in a timely manner.

If you are divorced, you may need to obtain a Qualified Domestic Relations Order (QDRO) to divide your pension benefit with a former spouse. See IN THE CASE OF DIVORCE under OTHER IMPORTANT INFORMATION in this section of the booklet for more information, including important details about submitting your retirement paperwork if you do not have a QDRO.

Plan Highlights

When you retire, the Retirement Plan will pay you a monthly income based on your years and months of credited service and your pay. You may also elect a pension payment option which will continue payments to your spouse or another named beneficiary after your death.

Some other Retirement Plan highlights include:

- Participation in the Retirement Plan begins on your first day with the Company; there is no waiting period to begin earning a benefit.
- You have a vested right to these benefits at age 55 or after five years of service with the Company.
- Your pension is based on your final pay and your years of credited service.
- You may retire as early as age 55 and qualify for reduced Retirement Plan benefits.
- If you retire before age 65 and have at least 30 years of credited service, there will be no reduction in your monthly pension benefit for early retirement.
- Once you submit your completed retirement paperwork and the 30th day prior to your pension date has passed, any elections you have made with respect to those benefits are irrevocable.
- In the event of your death while you are employed, the Retirement Plan may provide a pension for your spouse.

Eligibility

You are eligible to participate in the Retirement Plan if you are employed by Pacific Gas and Electric Company or any other company, association or credit union designated by the Board of Directors of Pacific Gas and Electric Company or any subsidiary or affiliate of PG&E Corporation designated by the Chief Executive Officer of PG&E Corporation to participate in the Retirement Plan.

Participation in the Retirement Plan is automatic. You begin accumulating service credit for Retirement Plan benefits based on your eligibility date in the Plan. Generally, this means you earn service credit beginning on your first day at work. See CREDITED SERVICE in this section of the booklet for important information on how your benefit is affected.

You are not eligible to participate in the Retirement Plan if you are a contract or agency worker, or a hiring hall employee.

Estimates of Your Pension Benefit

You have a right to know the amount of your vested monthly benefit in the PG&E Retirement Plan. To assist you in determining your accrued benefit, you may use the Pension Estimator that is located in the **Plans, Policies & Forms > Pension & 401(k)** section of the PG&E HR intranet site to calculate your estimated monthly benefit based on information and assumptions that you enter.

You may also request a pension estimate based on varying pension commencement dates and available joint pension options by sending an e-mail to the HR Service Center at *HRBenefitsQuestions@exchange.pge.com*, or you can contact the HR Service Center at 415-973-HELP (415-973-4357) or toll-free at 1-800-788-2363. If you are seriously considering retirement in the near future, you must notify the HR Service Center in writing at least 90 days before your proposed retirement date.

Pension estimates—whether performed by you or by the HR Service Center—are not binding and are subject to final review of payroll and employment data, as well as applicable Plan provisions. If a mistake is made, you will be paid the correct amount, even if that amount is less than the estimated amount.

How the Retirement Plan Works

How Benefits Are Determined

Benefits under the Retirement Plan are based on a formula that assumes you will retire at age 65. You may, of course, continue working beyond age 65. The actual amount you receive from the Retirement Plan will vary depending on when you choose to retire, your age when benefits begin, your pay rate, your length of credited service, and any joint pension election you choose. See YOUR PENSION BENEFIT in this section of the booklet for additional information.

When Benefits Are Payable

You must submit a Pension Elections Form to the Benefits Department in order to commence your pension benefit. Please note that if you delay the commencement of payments from the Retirement Plan, your pension benefit payments may increase. Refer to EARLY RETIREMENT and DEFERRED RETIREMENT in this section for more details. You should consider consulting a financial advisor before electing commencement of your payments.

Benefits from the Retirement Plan are available under each of the following circumstances:

Normal Retirement

Normal retirement refers to retirement at age 65. Your normal retirement date is the first day of the month after your 65th birthday.

Early Retirement

Early retirement refers to retirement between the ages of 55 and 65. You can elect early retirement as of the first day of any month after your 55th birthday. There is no minimum service requirement for early retirement. The shorter your service, the less you will receive from the Retirement Plan.

Deferred Retirement

Deferred retirement refers to retirement beyond your normal retirement date. If you work past your normal retirement date, you will continue to accrue credited service toward your pension benefit from the Retirement Plan. Your pension may also be actuarially increased to reflect the start of pension benefits following normal retirement age. You may elect to begin payment of your pension benefit when you actually retire. However, you must begin receiving benefits from the Retirement Plan no later than April 1 of the calendar year after you reach age 70½.

See MINIMUM DISTRIBUTIONS in this section of the booklet for additional information.

Death Benefit

If you are at least age 55 or have five or more years of credited service and your death occurs while you are a married participant in the Retirement Plan, your spouse is entitled to a benefit from the Retirement Plan (refer to SURVIVING SPOUSE'S PENSION in this section).

Termination Before Age 55

If you leave the Company before age 55 with at least five years of credited service under the Retirement Plan, you are entitled to a future benefit from the Retirement Plan. You may elect to receive your Retirement Plan benefit starting any time after reaching age 55. Please note that if you are subject to reductions for early retirement and choose to delay the commencement of payments from the Retirement Plan, your pension benefit payments may increase. However, your Retirement Plan benefit payments must begin no later than April 1 of the year after you reach age 70½. See MINIMUM DISTRIBUTIONS in this section of the booklet for additional information.

As a participant who terminated employment before age 55 with a vested benefit from the Retirement Plan, you are NOT considered a retiree of the Company and thus are ineligible for any other benefits that may be applicable to participants who are retirees as defined under the provisions of the Retirement Plan.

If you terminate employment before age 55 with a vested benefit you must request a Retirement Package in writing at least 90 days before the date on which you want to begin your pension benefit. Your completed paperwork must be received by the HR Service Center at least 30 days prior to your pension benefit commencement date. Once you have submitted your completed paperwork and the 30th day prior to your pension date has passed, all of your elections are irrevocable.

Minimum Distributions

Federal law imposes a minimum benefit amount that you must receive each year. This requirement typically applies if your first benefit payment begins after your normal retirement age or age 70½. The purpose of the law is to make sure individuals entitled to receive a benefit actually receive it during their lifetime.

If you are subject to the minimum distribution requirements, the Benefits Department will calculate the amount of the distribution that will satisfy the minimum distribution requirement for the Retirement Plan. If you participate in other plans, including any personal IRAs, the minimum distribution requirements for those plans or retirement accounts must be satisfied independently of the requirements for this Plan.

Your Pension Benefit

Basic Pension Benefit Formula

Your monthly benefit from the Retirement Plan is based on the following formula:

Final Basic Weekly Pay Converted to Monthly Equivalent Pay *	X	{ 1.5% X Credited Service Up to 25 Years	**PLUS**	1.6% X Credited Service Over 25 Years }	=	**Monthly Pension Benefit**

* Basic Weekly Pay as of 30 days before retirement/termination date, rounded up to nearest $10, multiplied by 52 weeks, divided by 12 months.

The following example illustrates the calculation of benefits for a hypothetical employee age 65 who retires on July 1, 2009, with 30 years of credited service. The terms "basic weekly pay" and "credited service" are defined after the chart.

- Basic Weekly Pay as of June 1, 2009 = $1,334.80 ($1,340.00 after rounding)
- Monthly Equivalent Pay = ($1340.00 X 52 / 12) = $5,806.67
- Credited Service = 30 years

MONTHLY EQUIVALENT PAY		FORMULA		MONTHLY PENSION BENEFIT
$5,806.67	X	{(.015 X 25) + (.016 X 5)}	=	$2,642.04

Basic Weekly Pay

Your "basic weekly pay" is equal to your straight-time rate of pay for the basic work week as of the 30th day before your retirement/termination, not including any temporary upgrade pay, or premium pay, or any benefits of any kind, rounded up to the nearest ten dollars.

This rate of pay is increased:

- by 6 percent for physical employees who qualify for rubber gloving premiums,
- by 2.75 percent for all clerical employees who received the 1988 lump-sum payment; or by 3.75 percent for clerical employees who received the 1988 and 1989 lump-sum payments; and
- by 4 percent for all former Pacific Gas Transmission Company employees who received the 1991 PGT lump-sum payment, and
- to a minimum basic weekly rate of pay of $1,109.99 for calendar year 2009, and increased in subsequent years to reflect applicable general wage increases.

Special rules may apply to the determination of the appropriate basic weekly pay in the event that:

- You have at least 10 years of credited service and, due to a lack of work situation or physical disability, you are demoted, or you transfer or bid down before your retirement date;
- You are an inactive employee not on long-term disability; or
- You are receiving long-term disability benefits.

Additional Retirement Income

A special Plan feature also provides for an additional monthly pension for Plan participants who receive shift premiums, Sunday premiums and nuclear premiums. This additional benefit is based on the average monthly straight-time premium received in the calendar year before retirement.

Credited Service

Eligibility for Credited Service

Generally, all eligible employees begin to earn service credit under the Plan upon employment.

Credited Service After 1975

You are given service credit for all periods of continuous employment with the Company, including periods when:

- you are on an authorized leave;
- you remain employed and are entitled to benefits from Pacific Gas and Electric Company's Sick Leave Plan, long-term disability plan, Workers Compensation, or the Supplemental Benefits for Industrial Injury Plan; PG&E Corporation's Disability Plans or State Disability Insurance Plan;
- you are in the military or merchant-marine service (as long as your re-employment rights are protected by law);

- you are laid off for lack of work for less than 12 continuous months and had less than five years of credited service; or
- you are laid off for lack of work for less than 24 continuous months and had more than five years of credited service.

Your credited service will end as of the earliest date on which you quit, retire or are discharged, or the date of your death. In addition, your credited service will end as of the first anniversary of the start of any period during which you are absent for any other reason and not earning credited service.

Credited Service Before 1976

Credited service prior to January 1, 1976, is calculated under the terms of the Retirement Plan in effect at that time. That is, if you joined the Retirement Plan when you first became eligible and were a regular employee who had completed one year of service, your credited service started with your employment date. If you did not join when you were first eligible and you did not take advantage of the one-time opportunity to “buy back” time in 1981, your credited service started with the date you joined the Retirement Plan.

Credited Service for Part-Time or Intermittent Employees After 1990

All credited service earned while you are a part-time or intermittent employee after December 31, 1990, will be prorated based on the ratio of actual straight-time hours worked in the calendar year to the full-time equivalent hours (2080). Special rules may apply if you became a part-time employee prior to 1991 and have continuous part-time service since that time. All service as a part-time or intermittent employee prior to January 1, 1991, will be considered full-time service.

A representative of the HR Service Center can help you calculate your total service credits under these rules. For information about how breaks in service affect Retirement Plan benefits, see BREAKS IN SERVICE in this section of the booklet.

Credited Service Upon Re-Employment

If you stop working for the Company and are later rehired, you may be eligible to receive credit for your past service. Whether your past service is counted depends upon the following:

1. the amount of credited service you had before you left the Company;
2. how much time passed before you were rehired;
3. when your termination and rehire took place; and
4. if you were a member of the Retirement Plan before 1972, whether or not you withdrew your contributions to the Retirement Plan.

Generally, you will not have a break in service if you return to work within 12 months after your service ends. In this case, your service will be considered continuous and will include the time you were not working for the Company. However, calculation of a break in service may be determined under different rules, depending on when the break occurred. See BREAKS IN SERVICE in this section of the booklet for important information on credited service.

Breaks in Service

If you do not meet the following requirements, your service before the break is not included in calculating credited service for the Retirement Plan.

Breaks in Service Beginning:

On or After January 1, 1989

If you had five or more years of credited service, your credited service before the break will be counted. If you had less than five years of credited service, your years of credited service will be counted if the period of the break was less than your credited service before the break.

On or After January 1, 1987, But Before January 1, 1989

If you had ten or more years of credited service, your credited service before the break will be counted. If you had less than ten years of credited service, your credited service before the break will not be counted if the period of break in service was equal to or exceeded the greater of:

- five years, or
- the period of credited service before your break in service.

On or After January 1, 1976, But Before January 1, 1987

If you had ten or more years of credited service, your credited service before the break will be counted. If you had less than ten years of credited service, your years of credited service before the break will be counted if the period of the break was less than your credited service before the break in service. In addition, the restoration of your past service credit will depend on whether or not you withdrew your contributions to the Retirement Plan when you left the Company. If you withdrew your contribution, you had to repay these contributions, plus interest, within two years of your re-employment to receive restoration of your past service credit. If you did not make the re-payment, your service credit was lost.

Before January 1, 1976

A “five-five-five” rule was in effect before January 1, 1976. Under this rule, upon either your death or retirement, your past service is counted if you:

- had at least five years of prior credited service,
- were rehired within five years of the date that your service ended, and
- worked at least five years after you were rehired.

Early Retirement

You can elect early retirement on the first day of any month after your 55th birthday and before your normal retirement date. You must contact the HR Service Center in writing at least 90 days before the date on which you want to retire. If you elect early retirement, your monthly pension benefit may be reduced to reflect the longer period of time you are likely to be receiving a pension. The amount of this reduction will depend on your years of service and your age when benefits begin, as shown in the following chart.

These reductions assume that your pension starts on the first of the month after your birthday. If you leave the Company or retire early but delay receiving pension payments, the reduction percentage will depend on your age when pension benefits actually start. Therefore, your monthly pension benefit may increase with delayed commencement of your pension payments.

For example, if you retire at age 55 with 20 years of service:

PAYMENT COMMENCEMENT:	SINGLE LIFE ANNUITY PAYABLE ON YOUR NORMAL RETIREMENT DATE (AGE 65)	REDUCTION PERCENTAGE (PER CHART)	PENSION BENEFIT AMOUNT AS A SINGLE LIFE ANNUITY
AGE 55	$1,000 per month	26%	$740 per month $1,000-($1,000 X .26) = $740
DELAYED TO AGE 60	$1,000 per month	6%	$940 per month $1,000-($1,000 X .06) = $940
DELAYED TO AGE 62	$1,000 per month	0%	$1,000 per month
DELAYED TO AGE 65	$1,000 per month	0%	$1,000 per month

REDUCTION PERCENTAGE				
AGE	REDUCTION IN YOUR PENSION IF YOUR CREDITED SERVICE IS…			
	Less Than 15 Years	15 to 24 Years	25 to 29 Years	30 Years or More
64	3%	—	—	—
63	6%	—	—	—
62	9%	—	—	—
61	12%	3%	3%	—
60	15%	6%	6%	—
59	18%	10%	9%	—
58	21%	14%	12%	—
57	24%	18%	15%	—
56	27%	22%	18%	—
55	30%	26%	21%	—

Note*:* Reduction factors are based on age in years and months prior to your normal retirement age (age 65). Although only ages as of your birth date are shown on this chart, the reduction factors change with each month worked after age 55.

For example, if an employee with less than 15 years of service retired at age 55, the reduction factor would be 30 percent. Each month worked past 55 will decrease the reduction factor. For example, at age 55 years and four months, the reduction factor would be 29 percent, and so on.

Deferred Retirement

You have the right to continue working past your normal retirement age (age 65) as long as you are able to perform the full responsibilities of your position.

- You will continue to accrue service credit toward your pension benefit from the Retirement Plan if you decide to work beyond your normal retirement date, but you cannot begin receiving benefits as long as you are still working. See WHEN BENEFITS ARE PAYABLE under HOW THE RETIREMENT PLAN WORKS in this section of the booklet for additional information.
- If you elect deferred retirement, your monthly pension benefit may be eligible for actuarial adjustment to reflect the shorter period of time you are likely to be receiving a pension. The amount of this increase will depend on how much additional pension benefit you earn with each year of service after age 65 relative to the applicable actuarial adjustment for these years.

You may apply to begin your pension benefit when you actually retire. However, you must begin receiving benefits from the Retirement Plan no later than April 1 of the calendar year after you reach age 70½.

See MINIMUM DISTRIBUTIONS in this section of the booklet for additional information.

If You Leave the Company Before You Are Eligible to Retire

If you leave the Company with at least five years of credited service but before the first day of the month after your 55th birthday, you have a vested pension benefit from the Retirement Plan. This means that you are guaranteed a pension benefit from the Retirement Plan when you reach retirement age. You can elect to begin receiving your pension benefit from the Retirement Plan at any time on or after the first day of the month following your 55th birthday. Your pension benefit will be calculated the same as for normal retirement and reduced, if applicable, using the appropriate early retirement reduction factor. You may also elect a joint pension, as described in PAYMENT OPTIONS.

If you leave the Company but delay receiving pension payments, the reduction percentage or actuarial adjustment percentage will depend on your age when pension benefits actually start. Therefore, your monthly pension benefit may increase if you choose to delay commencement of your pension payments (refer to the example under EARLY RETIREMENT). However, benefit payments must begin no later than April 1 of the year after you reach age 70½. **It is your responsibility to notify the HR Service Center in writing at least 90 days prior to the date on which you want your vested pension benefits to become payable. The Plan does not allow retroactive payments.**

See OTHER PENSION BENEFIT PROVISIONS in this section of the booklet for important information on payment provisions.

Payment Options

There are a number of Retirement Plan joint payment options from which you may choose when you retire. Your elections are made on your Pension Elections Form. To help you make the best decision for your needs, the HR Service Center will provide you with an estimate of the pension amounts you would receive each month under the various payment options available from the Retirement Plan.

In order to comply with ERISA requirements and to allow for administrative processing, your completed Pension Elections Form and supporting documents must be returned to the HR Service Center at least 30 days in advance of your first pension check. If your completed paperwork is not received on time (at least 30 days before your requested retirement date), your pension benefit will be recalculated to start the first of the month following the end of the 30-day period. For example, if your requested retirement date is May 1, 2010, and your completed paperwork is received on April 10, 2010, your new retirement date will be recalculated for June 1, 2010. The Retirement Plan does not allow retroactive payments.

If you are:

- divorced or divorcing, see IN THE CASE OF DIVORCE under OTHER IMPORTANT INFORMATION in this section of the booklet for more information, including important details about submitting your retirement paperwork if you do not have a QDRO.
- unmarried at the time you retire, or at the time you begin receiving payments from the Retirement Plan, you will automatically receive a Single Life Pension, with no provision for continuing payments to a survivor, unless you elect otherwise on the Pension Elections Form.

- married at the time you retire or at the time you begin receiving payments from the Retirement Plan, federal law requires that you be paid a 50 percent joint pension (a "Marital Pension") unless you and your spouse elect otherwise on your Pension Elections Form.

Single Life Pension

You may elect to receive your pension based on your own life expectancy only not provide any payments to a survivor. If you are married, your spouse must consent to this election in writing. **If you choose to provide no continuing pension for your spouse, both you and your spouse must sign the Pension Elections Form, and your spouse's signature must be witnessed by a Notary Public.**

Joint Pension

If you want to provide a continuing pension to someone in the event of your death, you may elect a "joint pension." You may designate anyone as your "joint pensioner." Your own pension benefit will be reduced so that up to 100 percent of this reduced amount can be continued to your joint pensioner in the event of your death. The amount your pension is reduced depends on your age and the age of your joint pensioner, as well as the percentage of your pension benefit that you elect to be continued to your joint pensioner.

Under a joint pension, your pension benefit will be calculated according to the Retirement Plan formula and then reduced by an actuarial factor. This reduction is necessary because payments are guaranteed for two people and are likely to be paid for a longer period of time. The amount of the reduction is determined by an actuarial factor based on your age and the age of your joint pensioner on your pension commencement date.

Here's an example:

Example of 50 Percent Joint Pension

- Employee is age 65; joint pensioner is age 62
- Basic monthly pension is $1,655.40
- Employee elects a 50 percent joint pension

Because the joint pensioner is younger, the joint pensioner is expected to live longer. It's also likely that payments would be made over a longer period of time since pension benefits under this option will continue throughout the joint pensioner's lifetime and not end with the pensioner's death. So the monthly pension is reduced, in this case, using a factor of .947.

.947 x $1,655.40 = $1,567.66

In other words, the reduced monthly pension is $1,567.66. In the event that the pensioner dies first, the joint pensioner would receive a lifetime continuing income of half this amount, or $783.83 per month.

$1,567.66 x 50% = $783.83

Joint pensions are available at 25 percent, 50 percent (the default Marital Pension for married employees), 75 percent and 100 percent of the pensioner's reduced monthly pension. You may elect any one of these joint pension options with any person you wish, subject to certain limits if your joint pensioner is more than 10 years younger than you are (for example, if you choose your child or grandchild as joint pensioner, the options higher than 50 percent may not be available for you to elect). **If you are married and you elect continued payments of less than 50 percent for your spouse, both you and your spouse must sign the Pension Elections Form, and your spouse's signature must be witnessed by a Notary Public.**

Special Joint Pension ("Pop-Up")

You may also elect a "special joint pension" which will allow your reduced monthly pension to increase or "pop up" to the full amount, as if you had never elected a joint pension, if your joint pensioner dies before you. However, your basic monthly pension benefit amount will be further reduced to reflect this additional benefit.

Changing Your Election

Once you elect a payment option, you may change your election up to 30 days before your pension date. In order to do so, you must complete a new Pension Elections Form and have it notarized. If you have submitted more than one Pension Elections Form, your pension benefit will be based on the most recently submitted correctly completed Pension Elections Form as of 30 days prior to your pension date.

Once you have submitted your completed paperwork and the 30th day prior to your pension date has passed, all of your elections are irrevocable. For instance, if you are receiving a pension benefit and your spouse dies before you do, your pension amount will not be increased unless you elected the special joint pension with your spouse. Your joint pension may not be transferred to another person.

Different rules apply if you elect a joint pension and either you or your joint pensioner dies before Retirement Plan payments begin. If your joint pensioner dies before your payments begin, the election you made on your Pension Elections Form will be ineffective and you will receive a Single Life Pension benefit.

If you are married and your death occurs within 30 days of your retirement date and you have submitted completed retirement paperwork to PG&E electing a joint pension with your spouse, your spouse will receive the greater of the joint pension you have elected or the Surviving Spouse's Pension, described below.

If your death occurs within 30 days of your retirement date and you are not married and have elected a joint pension, or if you are married and have elected a joint pension with someone other than your spouse, your joint pensioner will receive the joint pension percentage that you elected.

Surviving Spouse's Pension

The Retirement Plan may provide a pension benefit for your spouse in the event that your death occurs while you are married and you are employed by the Company. If eligible, the amount of your Surviving Spouse's Pension benefit will depend on your age and employment status at the time of your death.

If you elect a joint pension with your spouse, and your death occurs within 30 days after your retirement date, your spouse will receive the greater of the joint pension you have elected or the Surviving Spouse's Pension. However, if your death occurs after you have submitted your Pension Elections Form but before your retirement date, your spouse will only be eligible for the Surviving Spouse's Pension.

The Surviving Spouse's Pension is **not** applicable to unmarried employees, including unmarried employees with domestic partners.

Spouse's Pension A

If you are an employee earning credited service under the Retirement Plan and:

- you are age 55 or older when your death occurs, or
- your age plus years of credited service total to 70 or more,

your surviving spouse is entitled to a pension benefit equal to 50 percent of the basic pension you would have received had you elected retirement as of the first day of the month after your death. There is no reduction for early retirement. However, pension benefits will be reduced if your spouse is more than ten years younger than you. Your spouse's pension benefit will be reduced by 1/20 of one percent for each full month that your spouse is more than ten years younger than you. However, the total reduction cannot result in a smaller pension benefit than what your spouse would have received under a 50 percent joint pension with applicable early retirement reductions.

The Spouse's Pension A is payable on the first day of the month after your death and continues for the life of your surviving spouse.

Spouse's Pension B

If you have at least five years of credited service when your death occurs, and if your surviving spouse does not qualify for Spouse's Pension A, your spouse will be entitled to a pension benefit calculated under the formula for Spouse's Pension B.

For an Active Employee Who Dies Before Age 55

Your surviving spouse will be entitled to a 50 percent joint pension. This benefit will be calculated as if you had terminated employment on the date of your death.

Your spouse can elect to begin receiving this benefit on the first day of the month after you would have reached age 55.

For a Former Employee Who Dies Before Age 55

Your surviving spouse's benefit will be calculated as if you had survived until age 55 and elected a 50 percent joint pension. Your spouse can elect to begin receiving this benefit on the first day of the month after you would have reached age 55.

For a Former Employee Who Dies at Age 55 or Older

Provided you have not yet begun receiving pension payments from the Plan, your surviving spouse's benefit will be equal to the 50 percent joint pension that would have been payable to your spouse. The benefit is effective the first day of the month following the month in which your death occurs.

Other Pension Benefit Provisions

Mandatory Distributions

If you have a vested benefit from the Retirement Plan and the lump sum present value of your pension benefit is less than $5,000 as of the date you leave the Company or retire, you may elect to receive a single cash payment shortly after your employment ends or elect to roll over the distribution to a tax-deferred plan. You will receive a written explanation about rollover options prior to receiving your distribution from the Retirement Plan.

If you do not make an election and the lump sum present value of your pension benefit is:

- Less than $1,000, you will receive a single cash payment shortly after your employment ends.
- Greater than $1,000 but less than $5,000, the distribution will be paid as a direct rollover to an individual retirement account selected by the Benefits Department.

Past Employee Contributions to the Retirement Plan

This provision applies only to employees who were employed before 1973. If you made contributions to the Retirement Plan and have a vested benefit, you have the option at your retirement or termination of employment to withdraw these contributions, plus interest, or leave them in the Retirement Plan.

- If you leave your contributions in the Retirement Plan, you will receive the full pension to which you are entitled.
- If you withdraw your contributions, the pension you receive will be reduced by the actuarial value of the contributions withdrawn.

Please note that although the Retirement Plan rules allow you to withdraw an amount equal to your contributions plus accrued interest, tax laws no longer allow you to consider the portion of the refund equal to your contributions as non-taxable. Be sure you are aware of the tax implications before you request a refund of contributions from the Retirement Plan; you may wish to consult a tax advisor before doing so.

Other Important Plan Information

In addition to the benefit provisions explained in this summary, there are also a number of administrative matters you should know about. Some of these matters are described briefly in the following section.

Loss or Reduction of Benefits

There are certain circumstances under which your Retirement Plan benefits may be lost or reduced. These circumstances include the following:

- If you terminate employment with the Company prior to age 55 and before earning five years of credited service, you will lose your right to receive Retirement Plan benefits.
- If you elect to receive your Retirement Plan benefits in the form of a Single Life Pension, Retirement Plan payments will stop at your death. A continuing pension will not be paid to your spouse or any other person after your death.
- If your spouse qualifies for a surviving spouse's pension, the amount of this benefit will be reduced if your spouse is more than ten years younger than you.
- If you contributed to the Retirement Plan before 1973 and withdrew your contributions and interest when your employment terminated, any annuity or pension to which you are entitled will be reduced.

In the Case of Divorce

Under current California law, certain Company-provided employee benefits which you earn while married are community property and, thus, can be divided between you and your ex-spouse by court order in a divorce proceeding.

The Retirement Plan is a pension plan which is governed by the Employee Retirement Income Security Act of 1974 (ERISA). Under ERISA, Retirement Plan benefits may not be divided between the parties in a divorce **except through a Qualified Domestic Relations Order (QDRO).**

A QDRO is a judgment, decree or order which relates to the provision of child support, alimony or marital property rights to an alternate payee (including a spouse, former spouse, child or other dependents). It creates or recognizes the existence of an alternate payee's rights. The QDRO also assigns to an alternate payee the right to receive all or a portion of the benefits payable to a participant under a plan.

For detailed information regarding how divorce affects your Retirement Plan benefits, a copy of "Divorce Manual: *A Guide To Benefits At PG&E*", or a sample QDRO, you can visit the **Plans, Policies & Forms > Life Changes** section of the PG&E HR intranet site or you can call the HR Service Center at 415-973-HELP (415-973-4357) or 1-800-788-2363.

If you are ready to retire or begin your pension but you have not yet received a file-endorsed QDRO, you should submit your otherwise completed paperwork by the deadline for your desired pension date. Your pension payments will accrue monthly and be held back until PG&E receives the file-endorsed QDRO, at which point the accrued amount in accordance with the file-endorsed QDRA will be released to you with your first regular monthly pension payment. If you have submitted otherwise complete retirement paperwork, your retirement date and the

commencement of retiree medical, life insurance, and other retirement benefits, if applicable, will not be affected by the lack of a QDRO at the time you wish to retire.

Claims and Appeals

Claims

To receive a benefit from the Plan, you generally must complete a Pension Elections Form and provide any additional information needed to process your request and withhold taxes. If your request for a benefit is denied, in whole or in part, you have the right to appeal that decision.

Appeals

If you believe you have been denied a benefit to which you may be entitled under the provisions of the Retirement Plan, you may appeal your claim to the Benefits Department within at least 60 days following receipt of a notification of an adverse benefit determination by writing to:

Pacific Gas and Electric Company
Benefits Department
Retirement Plan Appeals
1850 Gateway Boulevard, 7th Floor
Concord, CA 94520

No special form or format is required in submitting a written appeal; you may submit written comments, documents, records, and other information relating to your claim. You may also request, free of charge, access to, or copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered at the initial benefit determination. Please note, however, that it is the obligation of the Benefits Department to administer the Plan fairly, consistently, and in accordance with the provisions of the Plan.

If the Benefits Department denies your claim, you will receive written notice of the denial within 90 days of receipt of the initial claim unless, due to special circumstances, an additional 90 days is required. Such notification will set forth:

- the specific reason(s) for the denial of the claim;
- a reference to the Plan provisions which apply to the denial;
- a description of any additional material or information necessary for a participant or beneficiary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures and the time limits applicable to such procedures; and
- a statement of the participant's or beneficiary's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

If you are not satisfied with the Benefit Department's decision, you may then submit a written appeal for review (within 60 days of receiving the Benefits Department's notice of denial) to the Employee Benefit Appeals Committee (EBAC), the final adjudicator in the appeals process, stating

the reasons for your appeal and enclosing all documentation and any additional information to support your appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
1850 Gateway Boulevard, 7th Floor
Concord, CA 94520

You will receive a final ruling from EBAC within 60 days of EBAC's receipt of your appeal unless, due to special circumstances, EBAC requires additional time to respond, up to another 60 days.

If EBAC denies your appeal, you will receive a written response which will include:

- the specific reason(s) for the denial of the claim;
- a reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under section 502(a) of ERISA.

Instead of electing to use the appeals steps through EBAC, a Bargaining Unit participant may use the grievance or adjustment procedure outlined in the appropriate collective bargaining agreement to resolve any dispute concerning questions of service, status or membership relating to Retirement Plan benefits.

Retirement Savings Plan

Detailed information about the Retirement Savings Plan (RSP) is included in a separate Summary Plan Description (SPD): The PG&E Corporation Retirement Savings Plan Summary Plan Description. The recordkeeper for the Plan, Fidelity Investments, will send you a copy of the Plan's SPD when you first become eligible to participate in the Plan. You may request a copy at any time by calling and speaking with a Fidelity Participant Services Representative at: 1-877-PGE-401K (1-877-743-4015).

Financial Engines®

When you participate in the RSP, PG&E also provides you access to Financial Engines at no cost to you. Financial Engines is an online investment advice tool that is accessible through the Fidelity website (*www.401k.com*) or directly at *www.financialengines.com*. Financial Engines can help you make informed investment decisions among the different investment options provided in the RSP and provide comprehensive financial advice based on your investment goals. Your RSP account balances are pre-loaded into Financial Engines for your convenience. All of the advice is independent, objective and customized to your life and your investments.

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ERISA Information

Your Rights Under ERISA

Participants in the Pacific Gas and Electric Company Retirement Plan entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining unit agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. You may also review all official plan documents, during normal business hours, in the Benefits Department.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now.

  If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if it finds your claim is frivolous.

Assistance with Your Questions

If you have questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Administrative Information About the Plan

NAME AND ADDRESS OF EMPLOYER	The Pacific Gas and Electric Company Retirement Plan is sponsored by: Pacific Gas and Electric Company 1850 Gateway Boulevard, 7th Floor Concord, CA 94520
EMPLOYER IDENTIFICATION NUMBER	The Internal Revenue Service has assigned this ID number to the Plan sponsor: Pacific Gas and Electric Company: 94-0742640
PARTICIPATING EMPLOYERS	The Pacific Gas and Electric Company PG&E Corporation PG&E Corporation Support Services, Inc. PG&E Corporation Support Services II, Inc.
PLAN NAME	The Pacific Gas and Electric Company Retirement Plan
PLAN NUMBER	001
PLAN TYPE	Pension: Defined Benefit
PLAN YEAR	1/1 – 12/31
PLAN ADMINISTRATOR	The Plan Administrator for the Plan is: The Employee Benefit Committee (EBC) of PG&E Corporation c/o Pacific Gas and Electric Company Benefits Department 1850 Gateway Boulevard, 7th Floor Concord, CA 94520
PLAN TRUSTEE, INSURANCE ISSUER AND/OR THIRD-PARTY ADMINISTRATOR	Plan Trustee: Mellon Bank One Mellon Center 500 Grant Street, room 1315 Pittsburgh, PA 15258-0001 See RETIREMENT PLAN FUNDING in this RETIREMENT INCOME PLANS section of the booklet for more information.

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DISCRETIONARY AUTHORITY	The Plan Administrator has oversight responsibility for the administration of the Plan which includes maintaining records, and making rules, computations, interpretations and decisions that may be necessary for administration of the Plan. The Plan Administrator has the discretionary authority to interpret, construe, and define the terms of the Plan.
AGENT FOR THE SERVICE OF LEGAL PROCESS	If you wish to take legal action after exhausting the applicable claims and appeals procedures, a lawsuit may be served on the Plan Administrator. Process may also be served on the Plan Trustee (see PLAN TRUSTEE, INSURANCE ISSUER AND/OR THIRD-PARTY ADMINISTRATOR for address). Service should be directed to: Linda Y.H. Cheng Vice President, Corporate Governance and Corporate Secretary Pacific Gas and Electric Company One Market, Spear Tower Suite 2400 San Francisco, CA 94105
OTHER ADMINISTRATIVE INFORMATION	ERISA divides employee benefit plans into two broad categories: welfare plans and pension plans. There are two types of "pension" plans. A "defined benefit" plan calculates your pension by using a formula; the amount of your benefit depends upon your pay and your credited service with the Company and A "defined contribution" plan provides an individual account for each participant; the amount you receive as a benefit depends upon the amount contributed to your account and the investment performance of the contributions. The Pacific Gas and Electric Company Retirement Plan is a defined benefit pension plan.
FUNDING	The Retirement Plan has been an employer-paid plan since 1973. The amount of each year's Company contribution is determined by the Employee Benefit Committee (EBC) based upon the advice of the Retirement Plan's actuary and in accordance with various laws and regulations which govern contributions to retirement plans. Company contributions are paid to bank trustees for safekeeping. Investment managers are appointed by EBC to direct the investment of the contributions paid to bank trustees. Bank trustees, insurance companies and investment managers are currently employed to invest or act as custodians of Retirement Plan assets (see RETIREMENT PLAN FUNDING in this RETIREMENT INCOME PLANS section of the booklet for more information).

The Pension Benefit Guaranty Corporation

For added security, the Company pays premiums to the Pension Benefit Guaranty Corporation (PBGC) to insure certain benefits under the Retirement Plan if that plan should terminate. Generally, if a plan should terminate, the PBGC guarantees most vested normal pension benefits, as well as certain disability and survivor pensions. The PBGC does not guarantee all types of benefits under covered plans, and the benefit protection is subject to certain limitations.

Basically, the PBGC insures vested benefits at the level in effect when the Plan terminates. However, if benefits have been increased in the five years immediately before the Plan terminates, certain restrictions may apply to the amounts guaranteed. In addition, there is a ceiling on the monthly amount guaranteed by the PBGC.

For more details about PBGC insurance, contact:

Pacific Gas and Electric Company
Benefits Department
1850 Gateway Boulevard, 7th Floor
Concord, CA 94520

1-415-973-4357 or 1-800-788-2363

or

Pension Benefit Guaranty Corporation
Insurance Operations Department
P.O. Box 19153
Washington, DC 20036-9153

1-800-400-7242
www.pbgc.gov

Plan Amendment and Termination

The Company, acting through its authorized representatives, reserves the right to amend or terminate the Plan at any time and for any reason, or suspend contributions to the Plan, in whole or in part, at any time.

Any change to the Pacific Gas and Electric Company Retirement Plan or the termination of the Plan will not affect the benefits payable to plan members before the date the Plan was changed or ended, but such change may result in reduced levels of benefits or benefit coverage, or higher levels of employee contributions, after the effective date of any such change.

In the event that the Company terminates the Plan for any reason without replacing it, you will be given notice. The Plan may be terminated by judicial action if the Company is bankrupt or insolvent, or upon complete dissolution, merger, consolidation or reorganization without provision by a successor-company for continuation of the Plan.

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Employees Represented by the IBEW, ESC or SEIU

January 2009