Pacific Gas and Electric Company
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LETTER AGREEMENT NO. 03-09-PGE

IBEW

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INDUSTRIAL RELATIONS DEPARTMENT
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INTERNATIONAL BROTHERHOOD OF
ELECTRICAL WORKERS, AFL-CIO
LOCAL UNION 1245, I.B.E.W.
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STEPHEN A. RAYBURN
DIRECTOR AND CHIEF NEGOTIATOR

PERRY ZIMMERMAN
BUSINESS MANAGER

March 5, 2003

Local Union No. 1245
International Brotherhood of Electrical Workers, AFL-CIO
P.O. Box 4790
Walnut Creek, CA 94598

Attention: Mr. Perry Zimmerman, Business Manager

Dear Mr. Zimmerman:

Effective January 1, 2003, the Department of Labor (DOL) mandated new appeals procedures for health care benefit plans. The new DOL mandated procedures primarily address the timeframe health care plans have to respond to certain types of appeals. Each medical, dental and vision plan vendor that administers benefits for PG&E employees has updated its appeals procedures to be compliant with the new DOL regulations. The Company has reviewed the new appeals procedures that PG&E health plan vendors are using and has determined that they are in compliance with the new DOL regulations.

These appeals procedures will supersede the appeals procedures outlined in Exhibit A, Dental Plan Benefits, Section 15 – Claims Appeal and Complaint Procedure, Exhibit B, Vision Service Plan, Section 8 – Claims Appeals Procedures, of the Medical, Dental, Vision Benefit Agreement dated January 1, 1994 and will also supersede Paragraph G and Attachment A of Letter Agreement 98-54-PGE regarding UnitedHealthcare.

PG&E will send copies of the health care plans' updated appeals procedures to all employees. In addition, employees can review the process on the Company's intranet benefit website, or by contacting the health care vendors.

In addition to the appeals procedures established by the Company's vendors in accordance with DOL regulations, outlined below is a voluntary review process that will be piloted in 2003 as an option to employees for PG&E's self-funded plans (UnitedHealthcare, Medco Health, ValueOptions, Delta Dental and Vision Service Plan) after employees exhaust the respective health care vendor's appeal process.

Appeals Program for the Self-funded Plans

Initial Steps

The vendors who administer the various self-funded plans sponsored by the Company administer the formal appeals process in accordance with the new Department of Labor (DOL) regulations. Exhaustion of the vendors' formal appeals process triggers the members' ERISA right to bring a civil action against the PG&E sponsored health plan.

The self-funded plans included in the voluntary review are the medical plans administered by UnitedHealthcare, the Prescription Drug Plan (Medco Health), the Mental Health, Alcohol and Drug Care Program (ValueOptions), the Dental Plan (Delta Dental), and the Vision Plan (Vision Service Plan). The Health Maintenance Organizations

(HMOs) are not eligible for the Voluntary Review Process, although the Benefits Department may assist members in resolving HMO problems.

Post Vendor Appeal Review

In addition to the DOL appeals processes administered by the vendors, in 2003 the Company will pilot a voluntary review process for claim appeals. The voluntary review is free to the member and can only be elected after the member exhausts the formal DOL appeals process with the health care vendor. The member has 90 days from the date of the final appeal decision from the vendor to elect to submit his/her appeal to the voluntary review process.

The Company's Voluntary Review Process is divided into two different processes, with each process having two levels of review. One review process is for the medical plans administered by UnitedHealthcare and for the Mental Health, Alcohol and Drug Care Program, and the other process is for the dental, vision and prescription drug plans.

PG&E Voluntary Review Process

Post Vendor Appeal Review for UnitedHealthCare Administered Plans, and the Mental Health, Alcohol and Drug Care Program

The Company's Voluntary Review Process for the UnitedHealthcare Plan and the Mental Health, Alcohol and Drug Care Program consists of the following two levels:

1. The first level of review is by the Benefits Department. The Benefits Department will consider the appeal and make a decision within 60 days of the date the appeal is received. If special circumstances exist, an extension up to 90 additional days may be required. The member will be notified if an extension is needed.

   Within the first level of review of appeals regarding UnitedHealthcare administered plans, the Benefits Department may request the member to initiate an External Medical Review. External Medical Review consists of an independent review by a third-party medical expert. It is triggered only if the appeal is based on one of the following:

   - Clinical reasons.
   - The exclusion for Experimental, Investigational or Unproven Services.

   External Medical Review is not available if the coverage determinations are based on explicit benefit exclusions or defined benefit limits. The External Medical Review is free to the member. The Benefits Department will uphold the recommendation of the External Medical Review if it is in the member's favor.

2. After the member exhausts the first level of voluntary review, the member may choose to proceed to the second level of the voluntary review process. The second level involves submission of the appeal to an independent neutral third-party selected from a pre-determined panel from the American Arbitration Association. The member must initiate the third-party neutral review within 60 days from the date of the Benefits Department's decision. The member may submit the appeal originally submitted to the Benefits Department to the neutral or supplement the appeal with any information the member deems relevant. The third-party neutral will issue a written decision to the member and the Company within 45 days from receipt of the member's appeals and the Company's position statement. The neutral's decision shall be binding on the Company, but not the member. The Plan will pay the neutral third-party's fees.

Post Vendor Appeal Review for the Prescription Drug Plan, the Dental Plan and the Vision Plan

The Company's Voluntary Review Process for the Prescription Drug, Dental, and Vision Plans consists of the following two steps:

1. The first level of review is conducted by the Benefits Department. The Benefits Department will consider the appeal and make a decision within 60 days of the receipt of the appeal. If special circumstances exist, an extension of up to an additional 90 days may be required. The member will be notified if an extension is needed.

2. After the member exhausts the first level of voluntary review, the member may choose to proceed to the second level of the voluntary review process. The second level involves submission of the appeal to the Employee Benefits Administrative Committee (EBAC). The member must submit the appeal to EBAC within 90 days from the Benefits Department decision. EBAC's decision will be made within 90 days from the receipt of the appeal.

The internal appeals process regarding eligibility remains unchanged.

If you are in accord with the foregoing and agree thereto, please so indicate in the space provided and return one executed copy of this letter to the Company.

Very truly yours,

PACIFIC GAS & ELECTRIC COMPANY

By: _____
Stephen A. Rayburn
Director and Chief Negotiator

The Union is in accord with the foregoing and agrees thereto as of the date hereof.

LOCAL UNION NO. 1245, INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS, AFL-CIO

Aug 28, 2003

By: _____
Perry Zimmerman
Business Manager