Pacific Gas and Electric Company

LETTER AGREEMENT
NO. R1-06-05-PGE

IBEW

PACIFIC GAS AND ELECTRIC COMPANY
INDUSTRIAL RELATIONS DEPARTMENT
2850 SHADELANDS DRIVE, SUITE 100
WALNUT CREEK, CALIFORNIA 94598
(925) 974-4104

INTERNATIONAL BROTHERHOOD OF
ELECTRICAL WORKERS, AFL-CIO
LOCAL UNION 1245, I.B.E.W.
P.O. BOX 2547
VACAVILLE, CALIFORNIA 95696
(707) 452-2700

STEPHEN A. RAYBURN,
DIRECTOR AND CHIEF NEGOTIATOR

PERRY ZIMMERMAN,
BUSINESS MANAGER

February 9, 2006

Mr. Perry Zimmerman, Business Manager
Local Union No. 1245
International Brotherhood of
Electrical Workers, AFL-CIO
P.O. Box 2547
Vacaville, CA 95696

Dear Mr. Zimmerman:

The Company proposes to revise the Claims and Appeals Procedure for the Long-Term Disability (LTD) Plan as contained in the attachment. These changes are in compliance with the Department of Labor rules effective January 1, 2006. This letter agreement supersedes Letter Agreement 01-62.

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,

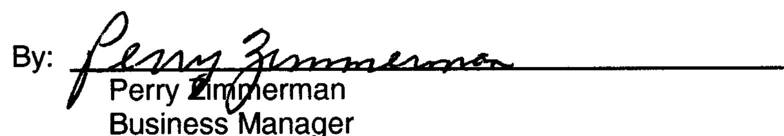
PACIFIC GAS & ELECTRIC COMPANY

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

Feb 14, 2006



By: ______________________
Perry Zimmerman
Business Manager

BENEFIT AGREEMENT

PART II

PART C – Applicable to the Entire Plan

2.25 CLAIMS AND APPEALS PROCEDURE

B. LONG-TERM DISABILITY

If you have applied for benefits under the Long-Term Disability Plan, you will receive a ruling from the third-party administrator (currently *Assurant, formerly known as* Fortis Benefits Insurance Company) within a reasonable period of time but not more than 45 days of the third-party administrator's receipt of your claim and evidence of medical disability that would preclude you from performing the normal duties of your *base* job *classification*.

Disagreements which may arise with respect to medical opinions as to whether an employee is or is not disabled within the meaning of the Long-Term Disability Plan shall be submitted to an impartial physician. In selecting the physician, Company will submit a list of more than two qualified physicians in the field to Participant or his collective bargaining representative who may select any one of these physicians. The employee will be referred to the physician so chosen for a medical examination and report. Company will pay the medical costs of such examination.

If you submit a claim which is incomplete or does not include the required medical evidence, the third-party administrator will notify you that *an extension will be needed and of additional information necessary for the third-party administrator to make a decision of your claim*. ~~notify you that your claim has been stopped, or tolled, for a period of up to 45 days until medical evidence is received or the claim is otherwise completed.~~ *The third-party administrator will provide this notice not more than 45 days after receipt of your claim. You will have 45 days to provide the medical evidence and/or other information necessary for the third-party administrator to make a decision. The third-party administrator will make a decision on the claim within 30 days after receipt of this information or after the expiration of your 45-day deadline to provide this information, whichever is earlier.*

Once a full and complete claim has been submitted, the third-party administrator may, due to matters beyond the Plan's control, extend their review of your claim for up to two additional 30-day periods if additional information is still needed, for example, additional medical information to support your claim. You must be notified before the end of the initial 45-day period *or second 45-day period in the case of incomplete claims,* if an initial extension of up to 30 days is required and told why the extension is necessary and when the third-party administrator expects to render its decision. If an additional 30-day extension period is required, you must be notified before the end of the first 30-day extension period and told why the second extension is necessary and when the third-party administrator expects to render its decision.

If you have been denied by the third-party administrator, your written denial from the third-party administrator will include:

- the specific reason(s) for the denial of the claim; and
- a reference to the specific Plan provision(s) on which the denial is based; and
- a description of any additional material or information necessary for you to obtain approval of your claim and why such information or material is necessary; and
- a description of the Plan's review procedures and the limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse decision on appeal; and
- if your denial is based on the third-party administrator's internal regulations, guidelines, protocols or any similar criterion, you will be notified accordingly and, upon request, provided with a copy of the applicable regulation, guideline protocol or other similar criterion, free of charge; and
- if your denial is based on a medical necessity, or an experimental treatment or a similar exclusion or limit, you will be notified as to the scientific or clinical reason for the denial and, upon request, provided with a copy of the explanation, free of charge.

If you are not satisfied with the third-party administrator's decision, you or your authorized representative may submit a written appeal to the Employee Benefit Administrative Committee (EBAC) stating the reasons for your appeal and enclosing all supporting documentation. Please note: Your further appeal to EBAC must be received by EBAC within 180 days of your receipt of the denial of your claim by the third-party administrator. EBAC's address is:

Pacific Gas and Electric Company
Benefits Department, ~~N2P~~*N3K*
P.O. Box 770000
San Francisco, CA 94177

No special form or format is required in submitting a written appeal; you may present the pertinent facts and other information in any words which you believe will further your appeal. You may request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim.

The EBAC review will take into account all comments, documents, records and other information that you submit with your appeal, regardless of whether such information was submitted or considered in the initial claim decision. *EBAC may require a hearing or any other investigative procedures it deems necessary to aid it in its determination.* Please note, however, that it is the obligation of the Plan Administrator to administer the plan fairly, consistently, and in accordance with the provisions of the Plan.

You will receive a final ruling from EBAC within a reasonable period of time but not more than 45 days from EBAC's receipt of your appeal unless, due to special circumstances, EBAC requires additional time to respond, up to another 45 days. If an extension of time is required, EBAC will notify you within the initial 45 days of why the extension is necessary and when EBAC expects to render its decision.

If your appeal is denied, you will be provided with:

- the specific reason(s) for denial of the appeal; and
- reference to the specific Plan provision(s) on which the denial is based; and
- notification that you may receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant your claim for benefits; and
- a description of any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under section 502(a) of ERISA; and.
- if your denial is based on EBAC's internal regulations, guidelines, protocols or any similar criterion, you will be notified accordingly and, upon request, provided with a copy of the applicable regulation, guideline protocols or any similar criterion, free of charge; and
- if your denial is based on a medical necessity or an experimental treatment or a similar exclusion or limit, you will be notified as to the scientific or clinical reason for the denial and, upon request, provided with a copy of the explanation, free of charge.
- ~~the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."~~

~~In addition to the foregoing, disagreements which may arise with respect to medical opinions as to whether an employee is or is not disabled within the meaning of the Long-Term Disability Plan shall be submitted to an impartial physician. In selecting the physician, Company will submit a list of more than two qualified physicians in the field to Participant or his collective bargaining representative who may select any one of these physicians. The employee will be referred to the physician so chosen for a medical examination and report. Company will pay the medical costs of such examination.~~

~~Alternatively, a~~A Participant who is a member of a bargaining unit under any collective bargaining agreement between the Company and any Union may use the grievance or adjustment procedure of the appropriate Collective Bargaining Agreement to resolve any dispute concerning any question of service, status or membership under the Plan.