LETTER AGREEMENT
No. R3-92-43-PGE

Pacific Gas and Electric Company
Industrial Relations Department
201 Mission Street, 1513A
San Francisco, California 94105
[415] 973-3420

International Brotherhood of
Electrical Workers, AFL-CIO
Local Union 1245, IBEW
P.O. Box 4790
Walnut Creek, California 94596
[415] 933-6060

Ronald L. Bailey, Manager or
David J. Bergman, Director and Chief Negotiator

Jack McNally, Business Manager

April 15, 1992

Local Union No. 1245
International Brotherhood of
Electrical Workers, AFL-CIO
P.O. Box 4790
Walnut Creek, CA 94596

Attention: Mr. Jack McNally

This affirms the parties' agreement pertaining to selection of a Managed Care Point-of-Service vendor as defined under Exhibit Q and Exhibit C of the 1991 Medical, Dental and Vision Benefit Agreement between Pacific Gas and Electric Company and International Brotherhood of Electrical Workers, AFL-CIO, Local 1245.

Pursuant to Exhibit Q of the 1991 Medical, Dental and Vision Benefit Agreement, our discussion meeting of March 26, 1992, and confirming your position stated in your letter dated March 23, 1992, (attached), Company proposes the selection of The Prudential as the managed care vendor for the PG&E Managed Care Point-of-Service Plan to be effective January 1, 1993. In making this selection the parties agree that Exhibit Q and Exhibit C of the 1991 Medical, Dental and Vision Benefit Agreement will be implemented as written and as clarified in this letter agreement.

Thorough review and analysis of the data in conjunction with the final vendor presentations made during the week of March 16, 1992, reinforce Company's belief that The Prudential is the most qualified and experienced vendor available to deliver and effectively administer the Managed Care Point-of-Service Plan designed by the parties as described in Exhibit Q.

The selection of The Prudential as the Managed Care Point-of-Service vendor and the administration of Exhibit Q and Exhibit C of the 1991 Medical, Dental and Vision Benefit Agreement will be subject to the following terms and conditions:.

A. The provisions of Exhibit Q and Exhibit C of the 1991 Medical, Dental and Vision Benefit Agreement, and this clarification document shall be enforceable among the parties through Title 102 of the Operating, Maintenance and Construction Agreement (Title 9 of the Office and Clerical Employees Agreement), effective January 1, 1991. The enforcement mechanism shall be a Business Manager's Grievance.

B. The reference to specialty care physicians in bullet item number 2 under access objectives in Exhibit Q of the 1991 Medical, Dental and Vision Benefit Agreement shall be interpreted as specialty physicians of the following categories:

- Obstetrics/Gynecology
- Dermatology
- General Surgery

C. The bargained language of Exhibit Q prevails pertaining to network eligibility. Network expansions will be implemented only if there is adequate network capacity to service all PG&E members in a particular geographic area meeting the network access criteria as defined in Exhibit Q of the 1991 Medical, Dental and Vision Benefit Agreement. Company proposes that any disputes regarding the application of this criteria be referred for investigation and resolution by the local Business Representative and Human Resources Manager, or their designees.

D. Selection of The Prudential as the vendor for the Managed Care Point-of-Service Plan does not run concurrent with the term of the Medical, Dental and Vision Benefit Agreement. Any change in vendor during the term of the Medical, Dental and Vision Benefit Agreement will require agreement of both parties.

E. The Appeals procedures designed by The Prudential are attached. These procedures address certain specific appeals categories (denial of medical necessity; denials of referral; denial above UCR; and issues pertaining to out-of-area travel) and define the formal procedure through which member appeals will be administered. Company proposes to incorporate these provisions as a clarification to Letter Agreement R3-92-43-PGE.

F. A transition plan will be developed and will include conditions such as pregnancy in the third trimester, hospitalizations on December 31, 1992, terminal cases and other conditions where a defined treatment plan exists and where disruption of treatment might be dangerous to the patient's health. The composition of these transition benefits will be reviewed by the parties. An expedited appeals procedure will be developed and implemented to resolve any member disputes regarding the application of the transition benefits. Any such appeals will be heard and resolved by an agreed to medical examiner on an expedited basis. Transition benefits and the expedited appeals process shall also be available to members during open enrollments subsequent to the January 1, 1993, Managed Care Point-of-Service implementation.

G. Quarterly meetings will be held between PG&E, IBEW Local 1245 and The Prudential, beginning the fourth Tuesday in May 1992. These meetings will initially be held on a more frequent basis as needed.

H. A senior contact individual with both PG&E and The Prudential will be provided to IBEW Local 1245. PG&E will be included in the communication process with the vendor in order to ensure appropriate and timely resolution of any issues identified.

I. In order to receive full network coverage for treatment by specialists a member must be referred by the Primary Care Physician. However, company will require that The Prudential allow for Primary Care Physicians to make specialty referrals in or out of the network with payment at in-network levels in order to ensure, where possible, specialty referrals within a 30 minute drive time from the member's residence. Under this approach Primary Care Physicians will refer to an in-network specialist if one is available within 30 minutes driving time from the member's residence. If an in-network specialist is not available, the Primary Care Physician will refer to an out-of-network specialist located within 30 minutes driving time from the member's residence, with payment at in-network levels. If there are no specialists available within this distance from the member's residence, the employee continues to be eligible for the in-network level of benefits and the Primary Care Physicians will refer the member to the nearest appropriate specialty care physician. Any member disputes regarding the application of this criteria will be resolved locally as described in item C. These criteria do not apply in the event of members being referred to Centers of Excellence.

J. As a reiteration of the commitment made by The Prudential, female members covered under this agreement may select any obstetrician/gynecologist (OB/GYN) for routine OB/GYN care. The OB/GYN must be within the same medical group as the Primary Care Physician (internist or family practitioner) chosen by the female member in order for the member to have direct access to an OB/GYN without a referral from her Primary Care Physician. The OB/GYN must obtain authorization for hospitalization, surgery and high-intensity diagnostic procedures.

K. Members will be designated as in or out of the network once a year prior to open enrollment. Any network expansions occurring subsequent to this open enrollment period will not affect member's network status. In the event of a mid-year expansion, members will not be required to join the Managed Care Point-of-Service plan, but may elect to do so on a voluntary basis.

L. A process will be developed and administered by The Prudential under which members may nominate physicians for participation in the Managed Care Point-of-Service network.

M. In the event that there is no network chiropractor available to members in a particular geographic area, the member may request authorization for a referral to an out-of-network chiropractor. Any such referrals approved by the chiropractic vendor will be covered at the in network level of benefit. A process will be developed and administered by The Prudential under which members may nominate chiropractors for participation in the chiropractic network.

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

Very truly yours,

PACIFIC GAS AND ELECTRIC COMPANY

By _____
Manager - Industrial Relations

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

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

April 16, 1992

By _____
Business Manager

APPEALS PROCEDURE
EXHIBITS C AND Q OF MEDICAL, DENTAL, AND VISION BENEFIT AGREEMENT

I. Appeals Procedure

A. Step One

Members are to call Prudential's Member Services Coordinators if they have concerns about their plan or coverage. If the coordinator is not able to resolve the member's concern, the member will be referred to a Prudential Quality Assurance Coordinator to initiate the appeals process. The member is encouraged to write his/her concerns in detail but a letter is not a requirement to initiate the appeals process. Prudential is required to acknowledge receipt of an appeal to the member within five working days. The Quality Assurance Coordinator and a register nurse will investigate the patient's problem and attempt to resolve it informally. If the problem is not resolved at this point, it will be heard by the Bay Area Appeals Committee which consists of physicians, nurses, Member Service Coordinators and administrative personnel. If the member is not satisfied with the committee's determination, the member may appeal the issue to Prudential's Appeals Committee in Los Angeles.

At both the Bay Area and Los Angeles levels, every attempt will be made to resolve a formal appeal within fifteen working days of the request. If the review is delayed for any reason the member will be informed in writing. The member will be offered a resolution in writing within seven days following the appeals meeting. If an appeal is not resolved within six months from the date the initial written appeals is received, the member will have the option of immediately submitting a written request to refer the issue the second level of the appeals procedure.

B. Step Two

The final level of appeal for members whose concerns are not satisfied with the determinations made at the local and regional appeals committee is arbitration. The arbitrator will be jointly selected by the member and the vendor through the American Arbitration Association. The costs of the arbitrator and any hearings, exclusive of the parties' presentations, will be shared equally by the member and the vendor.

II. Denial of Medical Necessity

Prudential may make denials for lack of medical necessity only after review by a physician. Both the provider and the member have the right to appeal.

III. Denial of Referral

If authorization for a procedure or a referral is denied, the Primary Care Physician should explain the denial and suggest alternative care, if appropriate. Both provider and member may appeal, informally through the medical group or Prudential's Medical Director and formally through the appeals process.

IV. Denial Over UCR (Usual and Prevailing)

In network benefits for either the Point-of-Service plan (Exhibit Q) or the PPO plan (Exhibit C) are based on fee schedule arrangements and member is not responsible for any charges above the scheduled amount or usual and prevailing charge (U&P).

If the member goes outside the network, all service are subject to U&P determination. The claim system screens each procedure by service code and geographical area by zip code of the provider then compares the charge to the 80th percentile. The portion of a provider's fee exceeding the usual and prevailing maximum is reviewed by the claims examiner. Based on set guidelines for fee reduction vs. total charge, the examiner will deny the portion above U&P with a message explaining the circumstances to the provider and member.

Appeals to U&P reductions are referred to a claim approver in technical service area. They will review additional supporting documentation, i.e., operative reports, pathology reports, or a letter from a physician. If it appears additional payments are warranted, the claim will be reprocessed and a letter sent to the member explaining the additional allowance. If the claim technician cannot determine if additional payments are warranted based on the information on hand, the claim is referred to the Assistant Claim Consultant, or Medical Director, if needed. After the review by an Assistant Claim Consultant and/or Medical Director, either additional payments will be allowed, or a letter explaining why no additional benefits are available will be sent to the provider and member.

Both the member and the provider may appeal the decision through the appeals process.

V. Application of 100% Payment Under Out-of-Network Conditions

Under certain conditions as provided in Exhibits C and Q, members may be eligible for payment at 100% of U&P when services are rendered out-of-network. Initially, members may request for full payment in the following manner:

1. The member may submit in writing or in a phone call to membership services who will document on the Prudential Member Services Documentation System.

2. The provider relations department will respond to the request within five working days.

3. If the member is not satisfied with the response in two above, the member may file a formal written appeal, or ask that the appeal be considered through the formal appeals process.

This section may be used for, but not limited to, charges when members reside 30 miles from participating PPO providers, out-ofarea travel, dependents living outside of the service area, and referrals from a participating provider to a non-participating provider. In the case of a request for full payment from a nonparticipating provider, the member must show evidence of a written referral from the participating provider.

1245

)CAL UNION

P.O. Box 4790
Walnut Creek
CA 94596
3063 Citrus Circle
415 933.6060
FAX 415 933.0115

Follow-up:		
RLB	INDUSTRIAL RELATIONS	JLB
DJB		NKJ
MAS	MAR 25 1992	BBS
DMS		DMG
LLB	SEE ME / REPLY FOR MY SIGN / HAROLD	MAH
JDS	FYI / FOR YOUR RECOMM. / FILE	

IBEW

International Brotherhood of Electrical Workers, AFL-CIO

Jack McNally
Business Manager

Howard Stiefer
President

March 23, 1992

Pacific Gas and Electric Company
Industrial Relations Department
215 Market Street
San Francisco, CA 94106

Attention: Mr. David Bergman, Director and Chief Negotiator

Mr. Bergman:

This letter serves to restate the position of Local 1245 regarding the Point-of-Service medical plan negotiated by the Company and Union.

As you are aware, PG&E, ESC, and IBEW participated in a joint study of medical delivery systems for a six-month period commencing in January of 1990. A very significant amount of time was spent on this project which culminated in an agreed-to recommendation for the parties to consider in general negotiations. Most of the recommendation was adopted by the Company and Union during the subsequent negotiations.

In the view of Local 1245, the access objectives agreed to by the parties is a key element to the program. Our opinion is not only based upon the requirement for basic medical services to be available within a reasonable distance from our members' residences, but, more importantly, this requirement would act as an incentive for the vendor to develop a more appropriate network for our members. Given this access requisite, Local 1245 proceeded to agree to the economic "drivers" that would encourage our members to utilize in-network services.

Accordingly, as stated in our meeting of March 19, Exhibit Q of the 1991 Medical, Dental and Vision Benefit should be implemented in the fashion as originally agreed to by the parties during general negotiations. Furthermore, it is our posture that this agreement as bargained will continue to meet the Company's financial expectations and the Union's concerns surrounding the delivery of medical care to our members.

With respect to the selection of the vendor, all of the potential vendors exhibited significant shortcomings, primarily due to the comparatively new concept of managed medical care. Local 1245 proposed to select the vendor that offered the most attractive financial picture to the Company; however, we would not object to Company's suggestion of selecting the vendor as recommended by William M. Mercer, Incorporated.

Local 1245 believes the foregoing would clarify any misunderstandings that may exist on this matter, and we are prepared to discuss this matter further anytime the Company may wish to do so.

Very truly yours,

Jack McNally
Business Manager

JM/fz