Pacific Gas and Electric Company
WE DELIVER ENERGY.

LETTER AGREEMENT NO. R1-02-03-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 4790
WALNUT CREEK, CALIFORNIA 94596
925-933-6060

STEPHEN A. RAYBURN
DIRECTOR AND CHIEF NEGOTIATOR

PERRY ZIMMERMAN
BUSINESS MANAGER

March 8, 2002

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:

The Company proposes to replace Part II, Part C – Applicable to the Entire Plan, Section 2.25 Claims and Appeals Procedure, Subsection A – Group Life Insurance of the 1994 Benefit Agreement in its entirety as contained in the attachment. These changes are in compliance with the Department of Labor rules effective January 1, 2002.

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
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

April 4, 2002 By: Perry Zimmerman
Perry Zimmerman
Business Manager

BENEFIT AGREEMENT

PART II

PART C – Applicable to the Entire Plan

2.25 CLAIMS AND APPEALS PROCEDURE

A. Group Life Insurance

To file a claim for benefits under the Group Life Insurance Plan, you or your beneficiary must contact the HR Service Center to obtain the proper claim form. You must follow the instructions on the claim form carefully and answer all questions completely to help expedite the processing of your claim. The completed claim form and any other required materials should be returned to the HR Service Center. The HR Service Center will forward your claim form to the carrier, Metropolitan Life Insurance Company, for further processing. Metropolitan Life Insurance Company is solely responsible for determining whether the benefit is payable under the Group Life Insurance Plan at the initial claim level and at the appeal level.

Determinations relating to eligibility under the Group Life Insurance Plan are made by the Plan Administrator at the initial claim level and by EBAC at the appeal level. If you have been denied benefits based on length of service, status, or membership in the Group Life Insurance Plan by the Plan Administrator, you may submit an appeal. The procedures governing claims and appeals are further described below.

Claims Relating to Payment or Denial of a Benefit

If your claim relating to the payment or denial of a Group Life Insurance Plan benefit has been denied by Metropolitan Life Insurance Company, 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 include:

- the 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;
- 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 your claim relating to the payment or denial of a Group Life Insurance Plan benefit has been denied by Metropolitan Life Insurance Company, you may submit a written appeal to Metropolitan Life Insurance Company. The appeal should be sent to Group Insurance Claims Review at the address of the Metropolitan Life Insurance Company office which processed your claim. Your appeal to Metropolitan Life Insurance Company must be received within 60 days of your receipt of notice that your claim has been denied by Metropolitan Life Insurance Company.

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 of your appeal by Metropolitan Life Insurance Company 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.

If Metropolitan Life Insurance Company denies your appeal, you will receive a written response which will include:

- the reason(s) for the denial;
- a reference to the Plan provisions which apply to the denial;
- 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;
- an explanation of any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- a statement of your right to bring an action under section 502(a) of ERISA.

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

This procedure is also outlined in ***More Information About Life Insurance*** in the section entitled ***Life Insurance Plans.***

Claims Relating to Service, Status, or Membership

If you have a claim relating to your length of service, status, or membership in the Group Life Insurance Plan that has been denied by the Plan Administrator, 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 include:

- the 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;
- 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 Plan Administrator's decision regarding your length of service, status or membership in the Plan, you may submit a written appeal to the Employee Benefit Administrative Committee (EBAC) at the address below:

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

Your appeal to EBAC must be received within 90 days of your receipt of the denial of your claim by the Plan Administrator.

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 of your appeal 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 EBAC to administer the Plan fairly, consistently, and in accordance with the provisions of the Plan.

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

- reasons for the denial of the claim;
- a reference to the Plan provisions which apply to the denial;
- 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;
- an explanation of any voluntary appeal procedures and your right to obtain information about such procedures; and
- a statement of your right to bring an action under section 502(a) of ERISA.

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.

Instead of electing to use the appeals steps through the Plan Administrator and 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 Group Life Insurance Plan benefits.