Welcome!

This is the 2014 edition of your Summary of Benefits Handbook, which describes your benefits effective January 1, 2014.

The Handbook contains valuable information about the following benefit programs that the Company offers to you and your eligible dependents.

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation. The plans and benefits described in this section are also applicable to employees of designated subsidiaries and affiliates, but only to the extent that such entities are participating employers with respect to the described plans or programs and such employees meet the eligibility requirements of the plans or programs.

- Health care plans (including prescription drug and mental health and substance abuse benefits), dental and vision coverage, the Employee Assistance Program, and the Wellness Program.
- Flexible Spending Accounts (FSAs) that can help you pay for certain health care and dependent care expenses on a before-tax basis. PG&E offers two FSAs — the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account.
- A Health Account will also be established for those enrolled in the Health Account Plan (HAP).
- Time off with pay such as vacation days, company-paid holidays, floating holidays, sick leave and leaves of absence, paid and unpaid.
- Disability benefits.
- Life and Accident Insurance plans, including Business Travel Insurance.
- Retirement benefits, including the Pacific Gas and Electric Company Retirement Plan, the Retirement Savings Plan and Retiree Health Care coverage.
- Work/Life Benefits, such as Adoption Assistance, the Commuter Transit Program, the Tuition Refund Program, discounts on gas and electric services for your home, as well as other Company-negotiated discounts.

Who Is Eligible

- **You are eligible** to enroll in the benefits described in this Handbook if you are a full-time, part-time or probationary union-represented employee.
- **You are not eligible** to participate in the benefits described in this Handbook if you are a temporary employee who is not expected to become a regular employee, a Management, Administrative & Technical employee, a contract, agency, or hiring hall employee; or a retiree of the Company.

Some benefits described in this Handbook, such as Retiree Health Care coverage, have additional criteria you must meet to be eligible.

The Benefits Available

The Company offers IBEW-, ESC- and SEIU-represented employees certain benefits that give you choices and may require you to make election decisions. Other benefits do not require election or enrollment decisions; you are automatically covered if you are an eligible participant. For details on the various plan provisions, see individual plan sections in this Handbook as well as:

- The *What If…* section for actions you may need or want to take when you experience a work/life event;
- The *Health Care Participation* section for health care plan eligibility and enrollment information;

Whether you have just joined the Company and are about to choose your benefits for the first time or you are considering changing your existing benefits elections, you should evaluate your options with care. Be sure to consider your future as well as your present needs when making your benefit decisions.

Questions?

If you have any questions about your benefits that are not answered by this Handbook or other benefit plan documents, you can contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-HELP (415-973-4357) or toll-free at 800-788-2363. You can also send an email to the HR Service Center at hrbenefitsquestions@exchange.pge.com or contact your union Business Representative or the Local Union Headquarters.

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About this Handbook

This Handbook and other applicable Summary Plan Descriptions (SPDs) are for your future reference when you want to find details about PG&E benefit plans and programs. When changes are made to these programs, PG&E communicates those changes to employees. In many, but not all instances, changes are communicated through Summaries of Material Modifications (SMMs) and other employee notices. SMMs are frequently part of the Open Enrollment materials. Please keep the communications that notify you of changes in the employee benefit programs with this Handbook for future reference. You can also access this Handbook and SMMs online at www.mypgebenefits.com and other reference documents on the PG&E@Work intranet site.

Plan Documents Govern

The plan document for the plans described in this Handbook, the terms of this Summary of Benefits Handbook which pertain to the respective plans, and the documents which are Summaries of Material Modifications to those plans govern the operation of the plans. If a conflict exists between these documents and any other communications or documents, these documents shall govern the operation of the plans. However, in the event of any conflict between the terms of this Summary of Benefits Handbook and/or Summaries of Material Modifications and the formal plan documents, the formal plan documents will control.

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

Xerox HR Services is the third-party administrator engaged by the Plan Administrator to fulfill certain recordkeeping and administrative functions for the Retirement Plan.

Plan Amendment and Termination

The Company, acting through its authorized representatives, reserves the right to amend or terminate any or all of the plans described in this Handbook at any time and for any reason, or to suspend contributions to the plans, in whole or in part, at any time, subject to any applicable collective bargaining agreements.

Any change to the plans or the termination of any plans will not affect the benefits payable to plan members (also known as “participants”) 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 a plan for any reason without replacing it, you will be given notice.

The plans may also 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 plans.

Benefits at a Glance

The Company gives you the opportunity to select from among a variety of benefits so you can tailor your benefits package to suit your own special needs. You have a choice of medical, dental, vision and life insurance plans, as well as other options, such as tax-free Flexible Spending Accounts (FSAs), for health care and dependent care expenses.

NOTE: This section is meant as a brief summary, and employees should refer to the appropriate sections of the Summary of Benefits Handbook for a more detailed discussion of each benefit. Benefits are governed by the terms of the respective plans themselves, not these summaries. Any inconsistencies will be governed by the terms of the plans.

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If You Have Questions

If you have any questions about your benefit options, dependent eligibility or any other benefits, you can send an email to the HR Service Center at hrbenefitsquestions@exchange.pge.com, or you can contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

In This Section

Health Care Eligibility at a Glance

Eligibility for you, the employee	In general, you are eligible for the health care coverage, regardless of whether you are a probationary employee or have reached regular status, if ▪ You are actively employed as a full-time or part-time employee, or a probationary union-represented employee. ▪ You are represented by the IBEW, ESC, or SEIU.
Eligibility for your family members	In general, the following are eligible dependents: ▪ Your spouse or domestic partner ▪ Your children who are under age 26, including stepchildren, children born during a registered domestic partnership, foster children, legally adopted children, and children for whom you have been permanently appointed legal guardianship by a court (does not include the legal wards of your spouse/domestic partner) ▪ The children of your registered domestic partner who are under age 26, including legally adopted children ▪ Your children who are eligible for coverage and become disabled before age 26 may be eligible for coverage beyond age 26 if their disability is certified before they lose eligibility For more information, see "Eligible Dependents" in the *Health Care Participation* section.
Who's Not Eligible For details on ineligible dependents, see "Ineligible Dependents" in the *Health Care Participation* section	In general, the following people are not eligible for coverage under the health care plans: ▪ Intermittent and temporary employees ▪ Contract employees ▪ Agency employees ▪ Former spouses and former domestic partners ▪ A child for whom your registered domestic partner is the legal guardian
Required Enrollment	▪ For most of the health care benefits, you must enroll to participate, and must do so within 31 days of becoming eligible. If you do not enroll yourself and your eligible dependents within 31 days of your becoming eligible, you may not be able to enroll again until the next annual Open Enrollment period, unless you experience an eligible change-in-status event.
When Participation Begins	▪ If you enroll as required, your coverage generally begins the first day of the month after your enrollment elections are received.

Enrollment Options at a Glance

This chart summarizes enrollment options for eligible employees as of January 1, 2014.

If you are an employee receiving benefits under the Long-Term Disability (LTD) Plan sponsored by the Company, your medical plan options will be one or more of the following: the Network Access Plan (NAP), administered by Anthem Blue Cross; the Comprehensive Access Plan (CAP) administered by Anthem Blue Cross, the Kaiser Exclusive Provider Organization (EPO) Plan and/or Kaiser Senior Advantage. The specific plan(s) that you are offered will be based on your home ZIP code and your Medicare eligibility.

For details about the Anthem NAP or CAP plans or Kaiser Senior Advantage plan, see "Medical Coverage" in the Health Care Benefits section of the 2011 Summary of Benefits Handbook for IBEW-, ESC- and SEIU-Represented Employees as modified by subsequent Summaries of Material Modifications (e.g., annual open enrollment guides), Evidences of Coverage and insurance policies, or see the most current summary plan description. For details about the Kaiser EPO Plan, please refer to the most current Kaiser Permanente Exclusive Provider Organization Plan Summary of Benefits Handbook.

Medical Coverage	▪ Depending on your home ZIP Code, you will be eligible for the Health Account Plan (HAP): ▫ administered by Anthem Blue Cross (Anthem HAP); and/or ▫ administered by the Kaiser Permanente Insurance Company (KPIC HAP). ▪ No Medical Plan ▫ See "Declining Medical, Dental and/or Vision Coverage" in the *Health Care Participation* section.
Mental Health and Substance Abuse (automatically included with medical coverage)	▪ Mental health benefits: ▫ Anthem HAP members: ValueOptions (VO) provides mental health treatment. ▫ KPIC HAP members: KPIC provides mental health services, including inpatient and alternate levels of care, intensive outpatient or partial hospitalization, and outpatient mental health treatment. ▪ Substance abuse treatment: ▫ Anthem HAP members: ValueOptions (VO) provides substance abuse treatment. ▫ KPIC HAP members: • Kaiser Permanente provides intensive outpatient, partial hospitalization and outpatient substance abuse services. • ValueOptions (VO) provides detoxification, inpatient and residential substance abuse treatment.
Prescription Drugs (automatically included with medical coverage)	▪ Anthem HAP members: ▫ Drug coverage (retail and mail-order) provided by Express Scripts Retail Pharmacy Service and Express Scripts Mail Order, respectively. ▪ Kaiser HAP members: ▫ Drug coverage (retail and mail-order) provided through Kaiser Permanente.
Dental Coverage	▪ Dental Plan administered by Delta Dental of California ▪ No Dental Plan ▫ See "Declining Medical, Dental and/or Vision Coverage" in the *Health Care Participation* section.
Vision Coverage	▪ Vision Plan administered by Vision Service Plan (VSP) ▪ No Vision Plan ▫ See "Declining Medical, Dental and/or Vision Coverage" in the *Health Care Participation* section.

Health Care Flexible Spending Account (HCFSA)	▪ You can allocate between $50 and $2,500 a year per individual. See "How Health Care Flexible Spending Accounts (HCFSAs) and Dependent Care Flexible Spending Accounts (DCFSAs) Work" in the *Flexible Spending Accounts* section for more information.
Dependent Care Flexible Spending Account (DCFSA)	▪ You can allocate between $50 and $5,000 a year per individual or married couple filing a joint tax return. (Employees with a spouse filing separate tax returns may each contribute up to $2,500.) See "How Health Care Flexible Spending Accounts (HCFSAs) and Dependent Care Flexible Spending Accounts (DCFSAs) Work" in the *Flexible Spending Accounts* section for more information.
Disability Coverage	You are automatically enrolled in the sick leave and/or company-sponsored disability programs at no cost to you, and in the California State Disability Insurance (SDI) Plan which you pay for with after-tax payroll deductions.
Life and Accident Insurance Coverage	▪ When you are eligible, you are automatically enrolled for $10,000 in Basic Life Insurance coverage, at no cost to you. ▪ You have the option to enroll for additional, supplemental life insurance coverage, up to a maximum of $1,000,000, at one of the following levels: ▫ Standard Life ($50,000) ▫ Life 1 (Equal to 1 times your annual pay) ▫ Life 2 (Equal to 2 times your annual pay) ▫ Life 3 (Equal to 3 times your annual pay) ▫ Life 4 (Equal to 4 times your annual pay) ▫ Life 5 (Equal to 5 times your annual pay) ▫ Life 6 (Equal to 6 times your annual pay)
Accidental Death & Dismemberment (AD&D) Insurance Coverage	▪ When you are eligible, you are automatically enrolled for $10,000 (or $250,000, depending on job level) in Basic Accidental Death and Dismemberment (AD&D) Insurance coverage, at no cost to you. ▫ You have the option to enroll for additional Voluntary AD&D Insurance coverage, at one of the following levels: • AD&D 1 (1 times your annual pay) • AD&D 2 (2 times your annual pay) • AD&D 3 (3 times your annual pay) • AD&D 4 (4 times your annual pay) • AD&D 5 (5 times your annual pay) • AD&D 6 (6 times your annual pay) • When you enroll, you have the option to enroll your spouse, registered domestic partner, your children or the children of your registered domestic partner for Voluntary AD&D Insurance coverage, at one of the following levels: ♦ Spouse or Registered Domestic Partner and Child(ren): An amount equal to 40% of your Voluntary AD&D Insurance amount for your spouse or domestic partner and 10% of your Voluntary AD&D Insurance amount for each child ♦ Spouse or Registered Domestic Partner Only: An amount equal to 50% of your Voluntary AD&D Insurance amount ♦ Child(ren) Only: An amount equal to 15% of your Voluntary AD&D Insurance amount for each child

Dependent Life and Accident Insurance Coverage	▪ You may elect Dependent Life Insurance coverage of up to $100,000 for your spouse or registered domestic partner and up to $25,000 for your children (limited to 50% of your total Basic and Supplemental employee coverage). See the *Life and Accident Insurance Plans* section of the Handbook for more information.
Business Travel Insurance (BTI)	▪ From your date of hire, Business Travel Insurance pays a benefit if your death or dismemberment is the result of a covered accident while traveling on company business or commuting to or from work, subject to a few limitations. See "Business Travel Insurance" in the *Life and Accident Insurance Plans* section of the Handbook for more information.
Retirement Benefits	▪ As an eligible employee, your participation in the Retirement Plan is automatic and at no cost to you. ▪ Generally, employees are eligible to enroll in the PG&E Corporation Retirement Savings Plan (also called the 401(k) plan) upon hire. You may enroll and have pre-tax, after-tax or a combination of these contributions deducted from your pay. If you are hired or re-hired on or after January 1, 2013, you will be automatically enrolled in the 401(k) plan after completing one year of service. ▪ You may be eligible for Retiree Medical coverage if you retire after age 55 and are eligible for early or normal retirement benefits under the terms of the PG&E Retirement Plan. If you are a union-represented employee who terminates employment on or after January 1, 2004, you must also have a minimum of 10 years of Service. ▪ When you retire after age 55, you will also be eligible for Retiree Life Insurance in the amount of $8,000. See the Retirement Benefits and Life and Accident Insurance Plans sections of this Handbook for more information.
Work/Life Benefits	▪ You may be eligible for a number of other benefits, such as the Adoption Expense Reimbursement Program, the Commuter Transit Program, the Employee Discount, Legal/Financial Solutions, the PG&E Children's Center, the Tuition Refund Program, and the Wellness and Health Advocacy Program. See the *Work/Life Benefits* section and the *Wellness and Health Advocacy Program* section for more information.

Declining Medical, Dental and/or Vision Coverage

If you are covered under another medical, dental, or vision plan outside of the Company (for example, through a spouse's employer), you may want to evaluate whether or not you need medical, dental or vision coverage through the Company. For information on declining coverage and opportunities that might allow you to enroll later, see "Declining Medical, Dental and/or Vision Coverage" in the *Health Care Participation* section.

Health Care Coverage at a Glance

These summaries cover the health care coverage options that may be available to you. Please note that availability of the KPIC HAP depends on where you live. For more detailed summaries, see each plan's section in this Handbook.

HAP Medical at a Glance

General	Annual deductible: ▪ $1,000/person; $2,000/family Annual out-of-pocket maximum (includes deductible): ▪ $2,400/person; $4,800/family Coinsurance: ▪ You pay 10% for primary care (beyond four free visits) with no deductible. ▪ You pay either 10% or 20% coinsurance depending on the type of provider and service. ▪ You pay no coinsurance for preventive care. No lifetime benefits maximum except for infertility services. No pre-existing condition exclusions.
	▪ All plan benefits and out-of-pocket maximums are based on eligible expenses only. For the definition of "eligible expenses," see the "Glossary" in the *Health Plan Account (HAP)* section. ▪ Both network and non-network covered expenses apply to deductible and out-of-pocket limits. ▪ Family deductible and out-of-pocket limits can be met by any combination of family members. Any family member can reach the single annual deductible and the plan will start to pay benefits for that person, even if the family annual deductible has not yet been met.
Hospital Stay	▪ You pay 20%, subject to deductible; expenses apply to out-of-pocket maximum. ▪ For the Anthem HAP: ▫ pre-authorization is required. ▫ out-of-network hospital-based physicians' services at in-network facility allowed at billed charges. ▪ For the KPIC HAP, your network physician will request pre-authorization.
Skilled Nursing Facility	▪ You pay 20%, subject to deductible; expenses apply to out-of-pocket maximum. ▪ No day maximum. ▪ For the Anthem HAP, pre-authorization is required.

Emergency Room	▪ You pay 20% for emergency room and physician, subject to deductible; expenses apply to out-of-pocket maximum. ▪ Accidental injury and medical emergency diagnosis pay as emergency. ▪ Services billed by a provider other than the hospital will be paid according to the appropriate benefit category level. ▪ For the Anthem HAP, out-of-network hospital-based physicians' services at in-network facility allowed at billed charges. ▪ For the KPIC HAP: out-of-network urgent and emergency care allowed at billed charges.
Outpatient Hospital Care	▪ You pay 20% for outpatient hospital care (including surgery, chemotherapy, radiation and dialysis services), subject to deductible; expenses apply to out-of-pocket maximum.
Maternity Care (professional)	▪ Routine pre- and post-natal office visits are free. ▪ You pay 20% after deductible for screenings and tests (for example, sonograms). ▪ You pay 20% after deductible for delivery. ▪ Includes nurse midwives, but excludes lay midwives and doulas (for the KPIC HAP, services must be received from network providers).
Well-Baby Care	▪ Fully covered up to age two.
Women's Preventive Care	▪ For Anthem HAP members: Birth control and contraceptive devices on the HAP Free Drug List fully covered if obtained at mail-order (retail coinsurance applies to retail purchases). ▪ For KPIC HAP members: With a prescription, birth control and contraceptive devices fully covered. Without a prescription, retail cost will be charged for retail purchases. ▪ Contraceptive counseling and implantable/injectable contraceptives fully covered. ▪ Voluntary sterilization fully covered.
Office Visits	▪ First four visits to a primary care physician (includes general or family practice, internal medicine, pediatrics, family nurse practitioner, obstetrics and gynecology) fully covered (employee and each enrolled dependent); if one of four visits is a physical exam, this counts toward the four free visits; you pay 10% for all subsequent visits, not subject to deductible; expenses apply to out-of-pocket maximum. ▪ Includes medically necessary non-routine vision and hearing care. ▪ For the Anthem HAP, the primary care physician (PCP) must be trained as a generalist for member to qualify for free visits. ▪ You pay 20% for all specialist office visits, subject to deductible; expenses apply to out-of-pocket maximum.
Urgent Care Visits	▪ Included as part of the four free visits to a PCP (employee and each enrolled dependent); you pay 10% for all subsequent visits, not subject to deductible; expenses apply to out-of-pocket maximum.
Routine Physical Examinations	▪ Free. ▪ Includes routine preventative gynecological exam.

Immunizations and Injections	▪ You pay 20% for injections, subject to deductible; expenses apply to out-of-pocket-maximum. ▪ Routine adult and child immunizations and travel immunizations are fully covered.
Routine Eye Examinations	▪ For Anthem HAP members: not covered (for details on routine vision coverage offered to employees, see the Vision section). ▪ For KPIC HAP members covered at 100%.
X-rays and Lab Tests	▪ Most preventive diagnostic X-ray and lab tests fully covered, including those on the free list. ▪ You pay 20%, subject to deductible for all other procedures, including diagnostic tests; expenses apply to out-of-pocket maximum.
Home Health Care and Home Hospice Care	▪ You pay 20% for home health care, subject to deductible; expenses apply to out-of-pocket maximum. ▪ For the Anthem HAP, precertification required. ▪ For the KPIC HAP, your network physician will request pre-authorization. ▪ Includes home infusion therapy and nursing care. ▪ You pay 20% for Bereavement counseling benefits subject to deductible, and benefits are limited to $25 per visit, four visits per family; expenses apply to out-of-pocket maximum. ▪ You pay 20% for respite care benefits, subject to deductible, of up to three days during a six-month period; expenses apply to out-of-pocket maximum. ▪ Hospice care fully covered. ▪ Home health care not covered while covered person receives hospice care. ▪ Excludes custodial care.
Outpatient Physical/ Occupational/Speech Therapy	▪ You pay 10% for first five visits and 20% for all subsequent visits, subject to deductible; expenses apply to out-of-pocket maximum. For purposes of determining coinsurance rates, tallying of the first five visits does not begin until the deductible has been met. ▪ Not combined with any other therapy. ▪ All visits may be reviewed for medical necessity; for the Anthem HAP, precertification is required for all visits beyond the 24th visit in a calendar year.
Durable Medical Equipment (Purchase & Rentals), Prosthetics and Orthotics	▪ You pay 20%, subject to deductible; expenses apply to out-of-pocket maximum. ▪ For the Anthem HAP, precertification required for purchase or cumulative rental exceeding $1,000. ▪ Includes colostomy/ostomy and urological supplies. ▪ Breast feeding pumps are fully covered. For Anthem HAP members: Pump must be purchased from a Durable Medical Equipment provider, not a retail store, in order for the equipment to be free. Call your HAP administrator (Anthem or Kaiser) for details.

Chiropractic Care	▪ You pay 10% for first five visits and 20% for all subsequent visits, subject to deductible; expenses apply to out-of-pocket maximum. For purposes of determining coinsurance rates, tallying of the first five visits does not begin until the deductible has been met. ▪ All visits may be reviewed for medical necessity; if you are in Anthem HAP, precertification is required for all visits beyond the fifth visit in a calendar year.
Acupuncture	▪ You pay 10% for first five visits and 20% for all subsequent visits, subject to deductible; expenses apply to out-of-pocket maximum. For purposes of determining coinsurance rates, tallying of the first five visits does not begin until the deductible has been met. ▪ All visits may be reviewed for medical necessity; if you are in Anthem HAP, precertification is required for all visits beyond the fifth visit in a calendar year.
Other Benefits	▪ Infertility treatment services are covered. You pay 20%, subject to deductible; expenses apply to out-of-pocket maximum. Lifetime maximum of $7,000. ▪ Transplants – You pay 20% for organ, stem cell and bone marrow transplants and bone marrow donor search services (unrelated family member), $30,000 maximum per search; travel and lodging for transplants covered up to $10,000 with authorization; bone marrow donor services and transplants performed at non-approved facilities for Anthem members, and by non-network providers for KPIC members are not covered. ▪ You pay 20% for hearing aids and exams to determine the need for hearing aids or the need to adjust them. You pay 20% for cochlear implants for adults and children (age 2 or older) for the following diagnoses: (1) severe to profound bilateral sensorineural hearing loss and severely deficient speech discrimination; or (2) post-lingual deafness in an adult. Hearing aid hardware is limited to one hearing aid per ear every three years. All covered expenses are subject to the deductible and apply to the out-of-pocket maximum. ▪ For the KPIC HAP, see "Other Covered Medical Services and Supplies" in the *Health Account Plan (HAP)* section for criteria for cochlear implant evaluation (required).

EAP at a Glance

Employee Assistance Program (EAP)	▪ The EAP is available to all active Company employees, as well as their spouses/registered domestic partners and their eligible dependents. ▪ The EAP provides assistance with issues such as: ▫ Family and relationship problems ▫ Workplace concerns ▫ Alcohol and drug issues ▫ Depression and anxiety ▫ Stress at home or work ▫ Financial and legal concerns ▫ Child and adult care referrals ▪ The EAP's services include: ▫ Up to six sessions per six-month period with a licensed EAP counselor ▫ A 30-minute telephonic consultation with a certified financial advisor ▫ A 30-minute telephonic or in-person consultation with an attorney ▫ Work/Life information and referrals to community-based services for child care, adult care, adoption and more ▫ Interactive online tools and resources available from work or home

Mental Health/Substance Abuse at a Glance

Mental Health and Substance Abuse Benefits	▪ Mental health and substance abuse benefits are provided through your medical plan coverage. The way you receive benefits varies, depending on which medical plan you are enrolled in. See "Mental Health and Substance Abuse" within the individual medical plan sections for more information.
Inpatient and Outpatient Mental Health Care	▪ You pay 20% for inpatient care covered charges, subject to deductible; expenses apply to out-of-pocket maximum. ▪ You pay 10% for outpatient care covered charges, not subject to deductible; expenses apply to out-of-pocket maximum. ▪ For Anthem HAP members: ▫ ValueOptions provides this care. ▫ Inpatient mental health requires preauthorization by ValueOptions; $300 penalty if you fail to notify within 48 hours; no limit on number of stays. ▫ ValueOptions covers emergency room services at 80% after deductible, for services coded with Mental Health and Substance Abuse (MHSA) code. ▪ For Kaiser HAP members: ▫ Kaiser provides this care. See "Mental Health and Substance Abuse" within the individual medical plan sections for more information.

Inpatient and Outpatient Substance Abuse	▪ You pay 20% for inpatient care, subject to deductible; expenses apply to out-of-pocket maximum. Pre-authorization required; $300 penalty for Anthem HAP members who fail to obtain pre-authorization. ▪ For Anthem HAP members: ▫ ValueOptions provides this care. ▫ Inpatient substance abuse requires preauthorization by ValueOptions; $300 penalty if you fail to notify within 48 hours; no limit on number of stays. ▫ ValueOptions covers emergency room services at 80% after deductible, for services coded with Mental Health and Substance Abuse (MHSA) code. ▪ For Kaiser HAP members: ▫ Kaiser provides outpatient substance abuse care. ▫ ValueOptions provides inpatient substance care, including detoxification and residential inpatient treatment. Preauthorization is required by ValueOptions; $300 penalty if you fail to notify within 48 hours; no limit on number of stays. ▪ You pay 10% for outpatient care covered charges, not subject to deductible; expenses apply to out-of-pocket maximum.
Applied Behavioral Analysis (Autism Treatment)	▪ No deductible. ▪ Free. ▪ No limit through ValueOptions. ▪ For Anthem HAP members: ValueOptions provides this care. ▪ For Kaiser HAP members: You may use ValueOptions or Kaiser. ▪ Preauthorization required with ValueOptions.
DOT- or NRC-Mandated Alcohol/Substance Abuse Treatment	▪ Fully covered (no deductible). ▪ Requires authorization by ValueOptions or an on-site EAP counselor.

Prescription Drugs at a Glance

Prescription drug coverage is offered to employees and their dependents who are enrolled in the Health Account Plan administered by Anthem Blue Cross or KPIC.

Both plan administrators provide retail and mail-order prescription drug coverage. If you are enrolled in HAP administered by Anthem Blue Cross, your prescription drug benefits are administered by Express Scripts.

The table below describes your prescription drug benefits if you are an Anthem HAP member:

Prescription Drug Benefits for Anthem Blue Cross HAP Members (Administered by Express Scripts)	
Retail Drug Purchases	**First three 30-day supplies** at a participating pharmacy: ▪ You pay 15% for generic drugs, 25% for brand-name drugs. **Fourth fill and beyond** of drugs **not on** mandatory mail-order drug list: ▪ You pay 15% for generic drugs, 25% for brand-name drugs. **Fourth fill and beyond** of drugs **on** mandatory mail-order drug list: ▪ No coverage for additional fills except through Express Scripts mail-order program. Through mail order, you're responsible for 10% of covered charges for generic; 20% for brand. Note: You need to use mail-order to get coverage for maintenance drugs. Generic Incentive Provision and Step Therapy Provision apply.

Prescription Drug Benefits for Anthem Blue Cross HAP Members (Administered by Express Scripts)	
Mail-Order Purchases	You pay 10% for generic drugs and 20% for brand-name drugs, up to a 90-day supply. Generic Incentive Provision and Step Therapy Provision apply.
Generic Incentive Provision	Member is responsible for paying the difference between the price of a generic drug and a brand-name drug, plus coinsurance, if purchasing a brand-name drug when a generic version is available. Please note that any generic-brand price differential you pay is a non-covered expense and, thus, does not count towards your annual deductible or out-of-pocket maximum.
Step Therapy Provisions	To ensure members have access to clinically appropriate medications, Express Scripts requires that members try generic medication or lower-cost brand-name alternatives first, instead of higher-cost brand-name drugs. Express Scripts will review and approve exceptions if brand-name drugs are required. Members may request such a review by submitting an appeal directly to Express Scripts.
Annual Deductible	Annual deductible coordinates with medical plan and mental health/substance abuse coverage; $1,000/individual, $2,000/family maximum. Deductible applies for all prescription drugs, except for preventive medications and devices listed on the Anthem Free Mail-Order Drug List.
Annual Out-of-Pocket Maximum	▪ $2,400 per person, $4,800 per family. ▪ Out-of-pocket maximum coordinates with the medical plan and mental health/substance abuse coverage. Covers both retail drugs and mail-order drugs. Non-covered expenses, such as generic-brand price differentials and other penalties, are not eligible expenses and thus, will not count toward your deductible or out-of-pocket maximum, nor will these expenses be covered by the Plan after your annual out-of-pocket maximum is met.
Lifetime Maximum	None.
Preventive Drugs and Devices	▪ Preventive medications fully covered at mail order only. ▪ Contraceptive devices (including birth control) are considered preventive and certain products are fully covered at mail order. (See the Anthem HAP Free Mail-Order Drug List for listing of free products.) Also available at retail pharmacies at designated retail coinsurance.
Infertility, Sexual Dysfunction and Memory Enhancement Drugs	▪ You pay 50% for both retail and mail-order plans. ▪ Medically necessary drugs are covered at standard reimbursement rates. ▪ Generic Incentive Provision applies.

The table below describes your prescription drug benefits if you are a KPIC HAP member:

Prescription Drug Benefits for KPIC HAP Members (Administered by KPIC)	
Retail Drug Purchases	You pay up to 15% for generic drugs and 25% for brand-name drugs, up to a 30-day supply.
Mail-Order Purchases	You pay up to 10% for generic drugs and 20% for brand-name drugs, up to a 100-day supply.
Annual Deductible	Annual deductible coordinates with medical plan; $1,000/individual, $2,000/family maximum. Deductible applies for all prescription drugs, except for preventive medications and devices.
Annual Out-of-Pocket Maximum	▪ $2,400 per person, $4,800 per family. ▪ Out-of-pocket maximum coordinates with the medical and mental health/substance abuse coverage. Covers both retail drugs and mail-order drugs. Non-covered expenses are not eligible charges and will not count toward your annual deductible or out-of-pocket maximum nor will these expenses be covered by the Plan after your annual out-of-pocket maximum is met.
Lifetime Maximum	None
Preventive Tier	▪ Preventive medications fully covered at either KPIC HAP pharmacies or mail order. ▪ Contraceptive devices (including birth control) are considered preventive and are fully covered.
Infertility, Sexual Dysfunction and Memory Enhancement Drugs	▪ You pay 50% for both retail and mail-order plans, unless medically necessary. ▪ Medically necessary drugs are covered at standard reimbursement rates.

Dental Coverage at a Glance

Delta Dental will pay a specified percentage of allowed expenses after you pay any applicable deductibles or coinsurance.

The following chart summarizes what the Plan will reimburse you for covered services.

Choice of Dentist	Any; for maximum benefits, use a PPO or Premier Dentist
Annual Deductible*	Delta Dental PPO Network ▪ $25/person and $75/family Delta Dental Premier Network or Non-Participating Dentist ▪ $50/person and $150/family For all covered services

Diagnostic and Preventive Care	No deductible You pay 15% of eligible preventive care, including: ▪ Two exams/year ▪ Full-mouth X-rays and Panorex films once every five years ▪ Bitewing X-rays twice/year for dependents up to age 18; once/year for adults age 18 and older ▪ Two cleanings/year ▪ Fluoride treatments ▪ Space maintainers
Basic Care	Deductible required You pay 15% of eligible basic care, including: ▪ Fillings ▪ Root canals ▪ Extractions ▪ Oral surgery ▪ Treatment of the gums (periodontia) ▪ Sealants for eligible dependents under age 16 ▪ Permanent first molars through age 8 ▪ Second molars through age 15
Major Care	Deductible required You pay 15% of eligible major care, including: ▪ Crowns ▪ Inlays ▪ Onlays ▪ Cast restorations ▪ Bridges ▪ Implants
Annual Maximum	$2,500/person (excludes orthodontia)
Orthodontia Benefit	You pay 50% of covered expenses; lifetime maximum benefit of $2,000/person

* If you use only Delta Dental PPO dentists throughout the full calendar year, you will pay the lower deductible. If at any time you use a non-participating dentist or a Delta Dental dentist who is only in the Premier network, the higher deductible will apply. The maximum total deductible you will pay in any calendar year is $50/person or $150/family because you won't be required to pay a separate deductible for using both a PPO dentist and a Delta Dental Premier or non-participating dentist.

Note: All benefits are subject to Delta Dental's usual, reasonable and customary allowances.

In addition to your coinsurance, you are responsible for any charges over what Delta Dental will allow. Please note that the annual deductible, annual maximum and orthodontia lifetime maximum are the same regardless of whether services are received by a Delta Dentist or non-participating dentist.

Reimbursement to members who do not use a Delta Dentist is based on the prevailing fee. The prevailing fee is the applicable percentage of the lesser of the fee charged or the fee which satisfies the majority of Delta Dentists for a single procedure as determined by Delta Dental of California.

Vision Coverage at a Glance

Vision care is administered by Vision Service Plan (VSP), which has a network of over 27,000 eye doctors. If you need help locating a VSP network doctor, call VSP at 800-877-7195 or visit www.vsp.com.

While you may receive vision care from any doctor you choose, using a VSP-network doctor has two advantages:

- Vision Service Plan pays VSP doctors directly, so there are no claim forms to submit. If you go to a non-VSP doctor, you will have to pay the doctor yourself and then file a claim with VSP for reimbursement. Your benefits may be less if you use a non-VSP doctor.
- Exams, standard lenses and frames, or medically necessary contact lenses from VSP doctors are covered after you pay a $10 exam copayment and/or a $25 materials copayment. (Both copayments apply to each covered person.)

For services and supplies you receive from non-VSP doctors, you will receive an allowance from VSP for covered services that generally will not fully reimburse you for all of your expenses.

Flexible Spending Accounts at a Glance

Health Care Flexible Spending Account (HCFSA)	▪ The account allows you to set aside pre-tax contributions, to reimburse your eligible health care expenses that are not covered by health care benefits. ▪ You can allocate between $50 and $2,500 a year per individual. For additional information, see "How Health Care Flexible Spending Accounts (HCFSAs) and Dependent Care Flexible Spending Accounts (DCFSAs) Work" in the *Flexible Spending Account* section.
Dependent Care Flexible Spending Account (DCFSA)	▪ The account allows you to set aside pre-tax contributions, to reimburse your eligible expenses to care for children or other dependents so you can work or attend school. ▪ You can allocate between $50 and $5,000 a year per individual or married couple filing a joint tax return. (Employees with a spouse filing separate tax returns may each contribute up to $2,500.) For additional information, see "How Health Care Flexible Spending Accounts (HCFSAs) and Dependent Care Flexible Spending Accounts (DCFSAs) Work" in the *Flexible Spending Account* section.

Health Account at a Glance

Health Account	▪ When you enroll in the Health Account Plan (HAP), once a year PG&E deposits an initial credit to your Health Account. In 2014, the amount of the credit is $750 for single coverage or $1,500 for family coverage for union-represented employees transitioning in to the HAP. For all other employees, including new hires in 2014 and beyond, the amount of the credit will be $500 for single coverage or $1,000 for family coverage. ▪ Once a year, when you complete your health screening and either test tobacco-free or participate in a smoking cessation program, you can earn additional credits worth up to $500 for single coverage or $1,000 for family coverage. ▪ Any remaining account balance at the end of the year, if applicable, will automatically roll forward to the next year as long as you remain eligible. If you terminate your PG&E-sponsored medical plan coverage, you will forfeit the balance in the account, unless: ▫ You enroll in the HAP through COBRA. (You'll still get annual contributions from PG&E but you cannot earn annual incentives.) ▫ You retire and are eligible for PG&E-sponsored retiree medical coverage whether or not you enroll in it. (You will get to keep your unused Health Account credits but there will be no more PG&E contributions and no annual incentives). ▫ You have unused Health Account credits before you go on Long-Term Disability and you are enrolled in a PG&E-sponsored medical plan. (You will get to keep your credits but there will be no additional PG&E contributions and no annual incentives). For additional information, see "How the Health Account Works" in the *Health Account* section.

Disability Coverage at a Glance

As a regular full-time, part-time, or intermittent employee, you are eligible for disability coverage under three different types of plans:

- Company-sponsored plans,
- Legislated plans, and
- Plan for Supplemental Benefits.

The Company offers you these benefits when you are unable to work due to illness or disability for either a short-term or long-term duration. Each of the plans is described briefly here; complete details of each plan follow later in this section.

The Pacific Gas and Electric Company Plans	Legislated Plans	Pacific Gas and Electric Company Supplemental Benefits
▪ Sick Leave ▪ Long-Term Disability (LTD)	▪ California State Disability Insurance (SDI) ▪ Workers' Compensation	▪ Supplemental Benefits for Industrial Injury

- Sick Leave — Provides continuation of your full salary for periods of illness or non-work-related injury based on annual sick leave awards and how much unused sick leave you have accumulated from past years.
- Long-Term Disability (LTD) — Provides you with income replacement if you become disabled because of an accident or a long-term illness and you are unable to work. This benefit, when combined with certain other sources of income that may be payable after the disability occurs, will be equal to either 50% or 66-2/3% of your basic monthly pay.

There are three different plans under which you may qualify for LTD benefits, depending on when you become eligible for LTD benefits and/or when the onset of your disability begins or began. Detailed information for each of these plans is provided under "Long-Term Disability" in the *Disability* section.

- Plan I: For employees who became eligible for LTD benefits prior to January 1, 2000.
- Plan II: For employees who became eligible for LTD benefits on or after January 1, 2000, and the onset of your disability was prior to:
  - June 1, 2003 (if IBEW Clerical, ESC or SEIU), or
  - October 1, 2003 (if IBEW Physical).
- Plan III: For employees whose onset of disability is on or after:
  - June 1, 2003 (if IBEW Clerical, ESC or SEIU), or
  - October 1, 2003 (if IBEW Physical).

- Legislated Plans — benefits paid in compliance with federal and state law:
  - California State Disability Insurance (SDI) — The State of California pays a temporary income benefit for non-occupational illness or injury.
  - Workers' Compensation — The Company pays benefits for industrial injury or illness.
- Supplemental Benefits for Industrial Injury —The Company pays a supplemental benefit, above Workers' Compensation disability income, if you sustain an injury or illness on the job and are entitled to Workers' Compensation temporary disability benefits.

Life and Accident Insurance at a Glance

To help you provide financial security for your loved ones in the event of your death or serious injury, the Company offers eligible employees:

- $10,000 of Company-paid basic term life insurance coverage, through the Group Life Insurance Plan; and
- The option to purchase additional, supplemental term life insurance coverage for yourself, your spouse or registered domestic partner and your children or the children of your registered domestic partner, through the Group Life Insurance Plan.
- $10,000 or $250,000 of Company-paid Basic Accidental Death and Dismemberment (AD&D) Insurance coverage, depending on your job level;
- The option to purchase additional, Voluntary AD&D Insurance coverage for you and your spouse or registered domestic partner, your children, and/or the children of your registered domestic partner; and
- Business Travel Accident insurance coverage.

Additionally, you may be eligible for continued life insurance coverage when you retire or end your employment.

Retirement Plans at a Glance

The Company 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 Retirement Plan is a "defined benefit" plan, which means eligible participants receive a fixed pension benefit that is based on a defined formula. There are two retirement benefit formulas that may apply, based on your employment date and, in some cases, your benefit election. These formulas are:
    - The Final Pay Pension formula, for employees who were participants in the Retirement Plan prior to January 1, 2013; and

    - The Cash Balance Pension formula, for employees who were hired after January 1, 2013 or employees who elected a Cash Balance Pension during the one-time pension choice period offered in 2013.
  - If you elected the Final Pay Pension formula, the Retirement Plan will pay you a monthly income based on your years and months of credited service and your pay when you retire at age 55 or later.
  - Under the Retirement Plan's Cash Balance formula, you can receive your vested cash balance account in a one-time lump sum payout or as a monthly paid annuity payable for your lifetime at any time beginning the first of the month after your employment ends.
  - For either formula option:
    - The benefit does not increase with inflation or otherwise over time; it is a fixed monthly amount for your lifetime.
    - You may also elect a pension payment option which will continue payments to your spouse or another named beneficiary after your death.
- The PG&E Corporation Retirement Savings Plan for Union-Represented Employees
  - The plan is a 401(k) plan, or a "defined contribution" plan. Eligible participants receive Company contributions made to the plan based on a defined matching contribution schedule.
  - 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.
  - When you participate in the Retirement Savings Plan (RSP) for Union-Represented Employees, the Company provides you access to Financial Engines — an unbiased, independent advisory firm offering RSP participants support and assistance in making RSP investment decisions.

More Retirement Plan Highlights

- Participation in the Retirement Plan begins on your first day with the Company; there is no waiting period to begin earning a benefit. See the "Participating in the Cash Balance Pension" and the *Participating in the Final Pay Pension Benefit* sections for information regarding eligibility to participate.
- In the event of your death while you are employed, the Retirement Plan may provide a benefit for your spouse or another beneficiary you designate.
- Under the Retirement Plan's Final Pay Pension formula, you earn a pension benefit based on your pay and your years of credited service at retirement.
- Under the Retirement Plan's Cash Balance Formula, you can receive your vested cash balance account in a one-time lump sum payout or as a monthly paid annuity payable for your lifetime at any time beginning the first of the month after your employment ends.
- You may retire under the Final Pay Pension formula as early as age 55, but the benefits will be reduced for early retirement unless you have enough credited service to qualify for an unreduced pension. 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.

Time Off Benefits at a Glance

Vacation	▪ Eligible Company employees earn paid vacation days under the Vacation Program. ▪ Vacation is earned “as you go,” based on straight time hours worked according to your length of service. ▪ You receive an additional five service anniversary days (40 hours) in the year in which you complete 5 years of service and in each fifth calendar year thereafter. ▪ For additional information, see "Other Time Off" below.
Paid Holidays	▪ You are eligible to receive holiday pay after completing six months of employment and attaining regular status. ▪ The Company recognizes ten public holidays and three floating holidays a year with pay. The ten recognized holidays are: ▫ New Year’s Day ▫ Martin Luther King, Jr. Day ▫ Presidents’ Day ▫ Memorial Day ▫ Independence Day ▫ Labor Day ▫ Veterans’ Day ▫ Thanksgiving Day ▫ Friday after Thanksgiving ▫ Christmas Day
Leaves of Absence	▪ The Leave of Absence policy enables you to take time off for medical reasons (for you or an eligible family member), to care for and bond with a new child, for military duty, or for other personal situations that are urgent and substantial.
Other Time Off	▪ You may be eligible for paid time off for jury duty, funerals, adoption, and voting. ▪ You may also be eligible for time off under the Family School Partnership Act (FSPA), the Victims of Domestic Violence, Sexual Assault, or Stalking Act (VDVA), the Victims of Crime Act (VCA), Victims of Crime to Testify, Civil Air Patrol Leave Emergency Duty Leave/Volunteer Firefighter Training or the San Francisco Family Friendly Workplace Ordinance (SF FFWO).

Work/Life Benefits at a Glance

The Company’s work/life benefits include:

- Adoption Expense Reimbursement Program: The program provides employees up to $2,000 for reimbursement of eligible expenses related to the adoption of children under the age of 18, including stepchildren.
- Commuter Transit Program: Provides you with the opportunity to purchase transit passes and pay for certain parking expenses with pre-tax contributions.
- Employee Discount: Pacific Gas and Electric Company offers its employees a 25% discount on Pacific Gas and Electric Company-supplied gas for an employee’s primary residence (domestic use only). The discount for PG&E supplied electric service is 25% discount on the full Tier 1 rate plus 25% of the charges for all usage in excess of baseline calculated using the Tier 2 rate.

- Legal/Financial Solutions (ValueOptions): Legal/Financial Solutions is available through the Company's Employee Assistance Program (EAP). If legal advice is needed, you can speak with a licensed attorney by telephone or in person. If financial advice is needed, you can speak with a certified financial advisor by telephone.
- PG&E Children's Center: The Children's Center, located at 77 Beale Street in San Francisco, provides day care for children ranging from six weeks to five years of age.
- Tuition Refund Program: The Tuition Refund Program allows you the opportunity to enroll in approved courses to support your educational goals. These approved courses are designed to assist you in performing your current duties in the most productive manner possible and to help enable you to assume new duties in the future.
- Work/Life Program (ValueOptions): The Work/Life program, administered by ValueOptions (VO), provides information and assistance in locating quality child care or elder care services locally and nationwide. Additional Work/Life resources are available.

What If…

PG&E's plans and programs are designed to be flexible so you can adapt to changes in your life, depending on the events that you experience. This section provides general information about how your benefits may be affected by those life events. Where appropriate, it offers tips about things you may want to consider, actions you may want to take and sources where you can find more information.

The events are grouped into the following categories:

- Work Events,
- Family Events,
- Health Events, and
- Annual Enrollment

This section also includes "Other Rules" on page 82, covering event-based rules.

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation. The plans and benefits described in this section are also applicable to employees of designated subsidiaries and affiliates, but only to the extent that such entities are participating employers with respect to the described plans or programs and such employees meet the eligibility requirements of the plans or programs.

Note

This section is just intended to be a useful guide discussing some, but not all, situations that employees and participants may experience. This is a summary only and benefits are governed by the terms of the respective plans themselves, not these summaries. Any inconsistencies will be governed by the terms of the plans.

In This Section

Work Events

The following subsections describe how your benefits are affected when the below work events occur and what actions you may need to take:

- When You Join PG&E,
- If You Transfer from a Management or Administrative & Technical Position,
- When You Reach Regular Status,,
- You Work a Reduced (Part-Time) Schedule,
- If You Take an Unpaid Leave of Absence,
- If You Leave PG&E, and
- When You Retire.

Your Benefits and Employee Status

Your benefits depend on your status as an employee, and any change in status, such as becoming disabled and going on Long-Term Disability or going on a Paid or Unpaid Leave of Absence, can affect your benefits. In addition, the cost to you for your benefits is affected by your status as either a full-time or part-time employee.

You Join PG&E

Step One — Understand Your Options

31-Day Deadline!

You must either fax or mail the completed enrollment form to the HR Service Center within 31 days of your hire date to avoid being placed in the limited Default Coverage mentioned here.

Review the New Hire Benefits Packet when you receive it.

PG&E offers you one medical plan—the Health Account Plan. This plan has two different plan administrators—Anthem Blue Cross and Kaiser Permanente Insurance Company (KPIC). You can estimate your costs under the Health Account Plan (HAP) using the **Medical Expense Estimator**. You can also calculate amounts to contribute to the Health Care Flexible Spending (HCFSA) account, including your potential tax savings by contributing to the HCFSA. See the description of this tool in the introduction to the *Medical Coverage* section.

You'll also receive enrollment information separately for the Retirement Savings Plan (RSP), mailed to your home from Fidelity Investments within two weeks of your hire date. Go online to Fidelity NetBenefits (www.401k.com) to learn about the importance of retirement savings, what an appropriate savings rate may be for you, and your investment options in the RSP.

Things to Consider	See…
What coverage is available to you automatically? ▪ If you do not enroll in your health care coverage within the time requirements, you will receive Default Coverage and you will not be able to change your coverage until the next Open Enrollment unless you have an eligible change-in-status event or qualify for a HIPAA special enrollment period. ▪ You're eligible to contribute to the RSP immediately upon hire. If you're hired or rehired after 2012, you will be automatically enrolled in the Plan and begin receiving PG&E matching contributions when you reach one year of service. ▪ You're also covered by the Retirement Plan immediately upon hire. There's no need to enroll — coverage is automatic.	▪ "Default Coverage" in this section and under "New Hire Enrollment" in the *Health Care Participation* section ▪ The *"Retirement Savings Plan" in* the *Retirement Benefits* section

Things to Consider	See…
If your spouse or registered domestic partner's employer offers benefits, should you be enrolled under their benefits instead? Can you share the coverage or coordinate your benefits? If you are covered under another medical plan, dental plan, and/or vision plan outside of the Company (for example, through a spouse's employer), you may want to evaluate whether or not you need medical, dental and/or vision coverage through PG&E. Employees covered by PG&E's benefit plans can elect to decline medical coverage, dental coverage, and/or vision coverage by selecting the "opt out" elections: NO MEDICAL PLAN (which includes no Mental Health and Substance Abuse or Prescription Drug coverage), NO DENTAL PLAN or NO VISION PLAN. You will not be able to re-enroll in a Company-sponsored medical, dental and/or vision plan until the next Open Enrollment period, unless you have an eligible change-in-status event or qualify for a HIPAA special enrollment period. Regarding retirement benefits, it's important and may be tax-efficient to save for your retirement individually, even if your spouse also has retirement savings opportunities.	▪ "If You Have Other Coverage" in the *Health Care Participation* section ▪ "HIPAA Special Enrollment Periods" in the *Health Care Participation* section ▪ The "Retirement Savings Plan" in the *Retirement Benefits* section
Is your spouse or registered domestic partner a PG&E employee? If you and your spouse or registered domestic partner are both union-represented employees, you or your spouse or registered domestic partner may have the option of being covered as an "employee" or "dependent", but you must choose one or the other. You cannot be covered as a family member and as an employee.	▪ "Employee/Retiree Couples" under "Eligible Dependents" in the *Health Care Participation* section

Things to Consider	See…
What are the enrollment deadlines to ensure you and your dependent are covered? Your medical, dental, and vision benefits, and any elected contributions to a Health Care or Dependent Care Flexible Spending Account, will go into effect on the first day of the month following the Company's receipt of your request to enroll, provided your request is received within 31 days of your hire date. For example, if you were hired February 1, and the Company received your request to enroll on February 15, your coverage will be effective on March 1. Upon completing six months of continuous service and attaining regular status, you will receive enrollment information for group life insurance. Your benefits will go into effect on the first day of the month following the Company's receipt of your request to enroll, provided your request is received within 90 days of the date on which you became eligible for group life insurance. You can elect life insurance up to two times your annual pay without evidence of good health, provided that you make such election within 90 days of initial eligibility. If elected within 90 days of eligibility, dependent life insurance coverage up to $25,000 will be automatically approved for your spouse or registered domestic partner. After 90 days, evidence of good health is required for any coverage request for the same spouse/domestic partner. You can enroll in the RSP at any time after you are hired — there are no time limits or restrictions. If you are hired or rehired in 2013 or later, you will be automatically enrolled as of the first pay period that starts 30 days after you complete one year of service, or as soon thereafter as practicable.	▪ "New Hire Enrollment" in the *Health Care Participation* section ▪ The "Retirement Savings Plan" in the *Retirement Benefits* section
What resources are available to you to learn about and select your benefits? A New Hire Benefits Packet will be provided to you within 10 business days of your date of hire. Review the options available to you and make your selections. You'll receive an RSP enrollment kit mailed to your home within two weeks of your date of hire. Go online or call Fidelity, the RSP administrator, to learn about your options and enrollment.	▪ "New Hire Enrollment" in the *Health Care Participation* section ▪ The "Retirement Savings Plan" in the *Retirement Benefits* section

Step Two — Take Action

Health Care

After you have reviewed your plan options, consider your family's health care needs. This will help you determine which coverage makes sense for your needs and theirs.

Then, complete the enrollment form included in your benefit enrollment kit and return it to the HR Service Center as indicated on the form.

What to Do	For Information and Assistance
Enroll yourself and your Eligible Dependent(s) within 31 days of hire.	
Submit your enrollment form by fax or mail. ▪ Complete the enrollment form included in your benefit enrollment kit and return it to the HR Service Center at the address or fax number indicated on the form. You'll receive a confirmation statement within 10 business days of the date on which your form is received.	▪ If you have any questions about enrolling in benefits, you can send an email to the HR Service Center at hrbenefitsquestions@exchange.pge.com or call the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.
Review your Confirmation Statement	
▪ Report any errors on your Confirmation Statement by contacting the HR Service Center within 10 business days of the date on which you receive your confirmation statement.	▪ If any of your information appears to be incorrect, you can send an email to the HR Service Center at hrbenefitsquestions@exchange.pge.com or call the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Declining Medical, Dental and/or Vision Coverage

If you are covered under another medical plan, dental plan, and/or vision plan outside of the Company (for example, through a spouse's employer), you may want to evaluate whether or not you need medical, dental and/or vision coverage through PG&E.

Employees eligible for PG&E's health care plans can elect to decline medical coverage, dental coverage, and/or vision coverage by selecting the "opt out" elections: NO MEDICAL PLAN (including no Mental Health and Substance Abuse or Prescription Drug coverage), NO DENTAL PLAN and/or NO VISION PLAN.

About Declining Coverage

If you decline medical, dental and/or vision coverage, here is some important information you need to know:

- **If you and your family member or registered domestic partner are both union-represented employees or are retirees**, you each have the option of being covered as an "employee" or "retiree," or you can be covered as a "dependent" of the other. However, you may not be covered as both. In addition, union-represented employees cannot cover a family member or a registered domestic partner who is a Management and Administrative & Technical employee.
- You will not be able to re-enroll in a Company-sponsored medical, dental and/or vision plan until the next Open Enrollment period, unless you have an eligible change-in-status event or qualify for a HIPAA special enrollment period.
- Declining or waiving coverage does not entitle you to receive additional compensation in lieu of Company contributions.

If you have any questions about declining medical, dental and/or vision coverage, you can send an email to the HR Service Center at hrbenefitsquestions@exchange.pge.com, or you can contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Default Coverage

If you do not enroll within the time requirements, you will be automatically assigned the following default coverage:

- No Medical Plan Coverage (including no Mental Health and Substance Abuse or Prescription Drug Plan benefits)
- No Dental Coverage
- No Vision Coverage
- Basic Life Insurance of $10,000 (after completing six months of credited service and attaining regular status)
- Basic AD&D Insurance of $10,000 (after completing six months of credited service and attaining regular status)
- No Flexible Spending Account Contributions
- Employee Assistance Plan

Once effective, your Default Coverage will remain in effect for the entire calendar year. You may not make changes to your coverage until the next Open Enrollment period, unless you have an eligible change in status or qualify for a HIPAA special enrollment period, as described in "Change-in-Status Events" on page 82 and "HIPAA Special Enrollment Periods" in the *Health Care Participation* section.

Retirement Savings Plan (RSP)

You'll receive an enrollment kit from Fidelity, the RSP administrator, within two weeks of your hire date. You may begin contributing to the Plan at any time, and you'll receive PG&E matching contributions as soon as you complete one year of service. You can enroll online at Fidelity NetBenefits (www.401k.com) or through the PG&E RSP Service Center at 877-PGE-401K.

If you are automatically enrolled in the RSP, you should review your plan contributions and investments to confirm that the default elections are appropriate for you. You can make changes through Fidelity NetBenefits online account services at http://www.401k.com or by contacting the RSP Service Center at 877-PGE-401K or 877-743-4015.

You Transfer from a Management or Administrative & Technical Position

If you are a Management or Administrative & Technical employee transferring into a union-represented position, your health and welfare benefits for Management and Administrative & Technical employees will continue until the end of the month in which you transfer. Your union-represented coverage will begin on the first day of the month following the date of your transfer.

Step One — Understand Your Options

One of your most important benefits is medical coverage, PG&E offers you one medical plan—the Health Account Plan. This plan has two different plan administrators—Anthem Blue Cross and Kaiser Permanente Insurance Company. One of the best ways to estimate your costs under the Health Account Plan (HAP) is to utilize the **Medical Expense Estimator**. You can also calculate amounts to contribute to the Health Care Flexible Spending account, including your potential tax savings by contributing to the HCFSA. See the description of this tool in the introduction to the *Medical Coverage* section.

Things to Consider	See…
When will benefits under your previous position expire? Do you need to seek other coverage until your new benefits become effective? Your benefits as a Management or Administrative & Technical employee will continue until the end of the month in which you transfer. Your benefits as a union-represented employee will begin on the first of the month following your date of transfer (i.e., no gap in coverage.) Certain restrictions apply to some benefits when transferring to a union-represented position. Be sure to understand how a transfer can affect medical, dental, and vision coverages, and flexible spending accounts, if applicable.	▪ The *Health Care Participation* sections in both versions of this handbook ▪ The *Time Off and Leaves* sections in both versions of this handbook
How different are your benefits now compared to the previous position's coverage options? And, how will your new take-home pay be affected, after contributions? Medical plan options are the same for Management and Administrative & Technical and union-represented employees. Your HAP deductible, out-of-pocket maximum and co-insurance status continues uninterrupted if you stay in the plan when your position changes. Other benefits offered to union-represented employees may be different than those offered to Management and Administrative & Technical employees. Be sure to review the options available to employees in your new position by referring to the sections listed at right.	▪ The *Benefits at a Glance* sections in both versions of this handbook, and the detailed plan descriptions in both handbooks ▪ "Cost of Coverage" in the *Health Care Participation* sections in both versions of this handbook ▪ The *Time Off and Leaves* sections in both versions of this handbook

Step Two — Take Action

What to Do	For Information and Assistance
Make your health and welfare elections within 31 days of your transfer date.	
Elect your coverage by the deadline. ▪ If you don't make your elections within 31 days of your transfer date, you will be assigned default coverage.	▪ If you have any questions about enrolling in benefits, call the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

As described below, certain restrictions apply when transferring to a Management or Administrative & Technical position.

Medical Coverage

- You may enroll in the Health Account Plan (HAP), or you may decline medical coverage. Enrollment in the HAP requires you to select a plan administrator—either Anthem Blue Cross or Kaiser Permanente Insurance Company. You must live in a Kaiser Permanente service area to select the KPIC HAP.

Dental and Vision Coverage

- You may enroll in the Dental Plan or you may decline coverage.
- You may enroll in the Vision Plan or you may decline coverage.
- If enrolled in the Vision Plan or Dental Plan prior to transferring, your coverage will continue.

Life Insurance Coverage

Your Life Insurance coverage will remain the same after a transfer, with no action required on your part. However, if desired, you may modify life insurance coverage at this or at any other time. You may also elect or modify dependent life insurance coverage for a spouse/registered domestic partner and/or your dependent child(ren) at any time. See the *Life and Accident Insurance Plans* section of this Handbook for additional information.

Voluntary Accidental Death and Dismemberment (Voluntary AD&D) Insurance Coverage

You may choose up to six times your base annual pay in Employee Voluntary AD&D Insurance coverage, with the first $10,000 in coverage being paid by the Company. In addition, you may elect Voluntary AD&D coverage for your spouse or registered domestic partner and child(ren). See the *Life and Accident Insurance Plans* section of this Handbook for additional information.

Flexible Spending Account Coverage

If you are contributing to a Health Care Flexible Spending Account (HCFSA) or Dependent Care Flexible Spending Account (DCFSA) before you transfer, you cannot change your HCFSA/DCFSA annual contribution amount(s) when you transfer; your contribution amounts will automatically continue. If your dependent care needs change as a result of your transfer, contact the HR Service Center within 31 days of your transfer.

Vacation Buy Days

If you have any unused Vacation Buy Days when you transfer from a Management or Administrative & Technical job, your unused Vacation Buy Day(s) will automatically be paid to you as taxable income at the same rate of pay at which they were originally purchased. If you have any Vacation Buy Days that have been used but not yet paid for, you will be billed for them at the rate of pay at which they were originally purchased.

Timeline for Elections after a Transfer

Your health and welfare elections must be made within 31 days of your transfer date. If you don't make your elections within 31 days of your transfer date, you will be assigned the following:

- Medical coverage:
  - If you are enrolled in the Health Account Plan (HAP) before your transfer, your coverage will continue and be administered by the same claims administrator (either Anthem Blue Cross or KPIC).
  - If you had no medical coverage before you transferred, you will continue to have no medical coverage.
- If you are enrolled in the Dental Plan when you transfer, you and any dependents that you are covering will continue to have coverage. If you are not enrolled in the Dental Plan before you transfer, you will continue to have no dental coverage.
- You and any dependents that you covered under the Vision Plan immediately prior to your transfer will continue to have coverage. If you are not enrolled in the Vision Plan when you transfer, you will continue to have no vision coverage.
- If you have at least six months of service when you transfer, you will be enrolled in the same level of life insurance and AD&D coverage you had prior to your transfer.
- HCFSA/DCFSA contributions, if applicable, will automatically continue.

You Reach Regular Status

Although you become eligible to enroll in Health Care and Retirement Savings Plan benefits when you are first hired, you do not become eligible for Group Life Insurance until you complete six months of credited service and reach regular status. Upon completing six months of continuous credited service and attaining regular status, you will receive enrollment information for the Group Life Insurance and Accidental Death and Dismemberment (AD&D) Plans. Your benefits will go into effect on the first day of the month following the Company's receipt of your request to enroll, provided your request is received within 90 days of the date on which you became eligible for group life insurance. Please refer to the *Life and Accident Insurance Plans*.

You Work a Reduced (Part-Time) Schedule

If you go on a part-time work schedule, you may continue participating in the same PG&E benefit plans. Some benefits may be reduced based on your part-time work schedule or the reduced pay that you received.

Step One — Understand Your Options

Things to Consider	See…
How will my health care coverage be affected? You will have the same health care coverage, but will pay a pro-rated medical premium based on your hours worked in addition to the 7.5% premium required for all active health care participants. No additional premium applies if you became a part-time employee prior to January 1, 1991. When you move to a part-time schedule, you may add or drop your spouse/registered domestic partner and other eligible dependents within 31 days of the change in schedule. If you have elected a Health Care Flexible Spending Account or a Dependent Care Flexible Spending Account, your participation continues. The dollar amount of your elected payroll deduction is not affected by a change in schedule.	▪ "Health Care Eligibility at a Glance" section ▪ "Contributions for Part-Time Employees" section of Health Care Participation
What will happen to my life insurance or disability coverage? Your life insurance coverage options and premiums are based on your full-time equivalent base pay and will not change due to a reduced work schedule. Part-time employees are covered by the same disability plans. Benefits may be prorated to reflect your reduced hours worked.	▪ "How Much the Plan Pays" under the "*Long Term Disability Plan*" section

Things to Consider	See…
How will future pension benefits be affected? You will continue to participate in the Retirement Plan and earn pension credits. Benefits earned before working a part-time schedule will not be reduced; future pension accruals may be affected by a reduced work schedule. Employees in the Final Pay formula earn prorated credited service based on the ratio of actual straight-time hours worked in the calendar year to the full-time equivalent hours. Your monthly rate of pay is not prorated to reflect your reduced work schedule; the full-time equivalent rate of pay is used to calculate your pension. Employees earning a Cash Balance benefit earn pay credits based on actual pay received for straight-time hours worked. For purposes of determining annual pay credits (the Age + Service formula that determine pay credits of 5% to 10% of pay), service is not prorated for part-time service.	▪ "Your Pension Benefit" in the *Retirement Plan - Final Pay Pension Benefit* ▪ "How The Cash Balance Pension Works" in the *Retirement Plan – Cash Balance Pension Benefit*
How will contributions to your Retirement Savings Account and RSP loan payments be affected? Employee contributions and company matching contributions are based on regular straight-time pay received. RSP loan payments are not affected by a change to a part-time schedule.	▪ The "Retirement Savings Plan" in the *Retirement Benefits* section
How will a reduced schedule affect how sick leave accruals or how sick leave is charged? Employees on a part-time schedule receive a prorated amount of annual sick leave based on the number of actual hours worked in the previous calendar year compared to 2,080 hours. Awards of additional or "bonus" sick leave are similarly prorated based on hours worked over the last 8 years. If you change from full-time to part-time status during the year, you keep the sick leave you have earned, and are awarded future annual sick leave on a prorated basis beginning the following January 1. When taking sick leave while on a part-time schedule, you are charged with the same number of sick leave hours as the hours you are scheduled to work on the day sick leave is taken.	▪ "Sick Leave" in the *Sick Leave & Disability* section

Things to Consider	See…
How are paid holidays treated if you are working part-time? For company holidays, part-time employees are allocated a pro-rated paid holiday based on work schedule. If the holiday falls on a weekend or non-workday, you will be credited a prorated paid holiday for later use. Employees working a reduced hour schedule receive the same 24 hours of floating holidays each January 1 that are awarded full-time employees. You can use a floating holiday on any regularly scheduled day of work. You will be paid for 8 hours whenever you use a floating holiday, regardless of the number of hours you are scheduled to work on the day the floating holiday is taken.	
How does a reduced hour work schedule affect paid vacation? For regular vacation accrual, you accrue vacation hours on an "earn-as-you-go" basis reflecting your straight time hours worked. For service anniversary vacation, your allocation is based on the number of straight-time hours worked during each of the last five years. When using vacation hours, you are charged with the same number of vacation hours as the hours you are scheduled to work on that day. Unused vacation and floating holidays will be automatically deferred up to the maximum allowed vacation bank of two times your current annual accrual rate. The maximum bank is not reduced for part-time service; the full-time equivalent bank continues to apply. Excess hours above the maximum allowance will be paid out to you the following February.	

Step Two — Take Action

Take the actions described in the following table to make sure you have the benefits you need.

What to Do	For Information and Assistance
Initiating a Change to Part-Time A change in work schedule must be initiated through your supervisor. Except as noted below, all benefit changes associated with a reduced work schedule are automatic and do not require action by you.	▪ Discuss with your supervisor. ▪ E-mail the HR Service Center at hrbenefitsquestions@exchange.pge.com, or call Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

What to Do	For Information and Assistance
No later than 31 days after your schedule change, make any elected changes to your health enrollment If you miss the 31-day deadline, you may not be able to change your coverage until the next annual enrollment period.	▪ E-mail the HR Service Center at hrbenefitsquestions@exchange.pge.com, or call Company extension 8-223-4357, externally at 415 973 4357 or toll-free at 800 788 2363.

You Take an Unpaid Leave of Absence

If you go on an unpaid leave of absence, you will continue to earn service credit under the Pacific Gas and Electric Retirement Plan. You may decide to continue the medical, dental, and vision coverage you elected but the amount you pay for such coverage may increase depending on the type of leave you are on and the duration of your leave. If you terminate your PG&E-sponsored medical plan coverage, you will no longer be eligible to participate in the Health Account because eligibility for the Health Account is tied to your enrollment in the Health Account Plan (HAP).

Basic Life and Basic Accidental Death and Dismemberment (AD&D) coverage will continue at no cost to you for the duration of your leave. Voluntary AD&D coverage, Supplemental Life, and Dependent life coverage will remain active. Premiums wills be suspended while you are on leave. Upon return to work, deductions will resume and the suspended premiums will be deducted from your first payroll check.

You can only contribute to the Retirement Savings Plan (RSP) through payroll deductions, so if you take an unpaid leave your contributions will stop. However, when you return, your contributions will automatically resume at the last percentage rate you elected. If you have an RSP loan, you may elect to make payments directly to Fidelity, defer payments while you are on leave (up to 12 months) and re-amortize the loan when you return, or default on the loan and pay tax penalties.

Step One — Understand Your Options

Things to Consider	See…
Which type of unpaid leave of absence applies to my situation?	▪ "Types of Leave" under "Leaves of Absence" in the *Time Off and Leaves* section
How will contributions to your Flexible Spending Accounts (FSAs), be affected? Salary contributions will no longer be contributed to your Health Care Flexible Spending Account (HCFSA) or your Dependent Care Flexible Spending Account (DCFSA). Your HCFSA participation continues if you elect to contribute on an after-tax basis while you are on unpaid leave. Your DCFSA participation stops while you are on unpaid leave.	▪ "If You Take a Leave of Absence Without Pay" in the *Flexible Spending Accounts* section

Things to Consider	See…
What will happen to my Health Account participation? If you do not continue enrollment in the Health Account Plan (HAP) during an unpaid leave of absence, then you will no longer be able to participate in the Health Account. Additionally, expenses for health care services incurred during the period of the leave when you were not enrolled in the HAP are not eligible for reimbursement. If you re-enroll in the HAP as an active employee in the same calendar year, your Health Account balance will be reinstated.	▪ "If You Take a Leave of Absence Without Pay" in the *Health Account* section
How will contributions to your Retirement Savings Account and RSP loan payments be affected? Salary contributions and loan repayments will be suspended while you are on leave. You may choose to make loan payments directly to Fidelity while you are out, or you may defer payments (up to 12 months) or default on your loan.	▪ The "Retirement Savings Plan" in the *Retirement Benefits* section

The following chart summarizes how your benefits are affected while you are on an unpaid leave of absence. As referenced in the chart:

- The "monthly cost" is the monthly employee contribution amount paid the month prior to going on an unpaid leave of absence, unless you subsequently add or drop a dependent or if your monthly contribution otherwise changes; and
- The twenty-four months of health care benefits continuation coverage and special provisions for Retirement Saving Plan contributions, withdrawals and loan repayments under the Uniformed Services Employment and Re-Employment Rights Act (USERRA) apply to elections made on or after December 10, 2004.

Benefit Coverage for Each Unpaid Leave Type			
Benefits	**Medical**	**Personal**	**Military**
Medical Plan (including prescription drug, and mental health and substance abuse benefits)	*Full-Time and Part-Time Employees* You may elect to continue coverage up to 12 months, paying the same monthly cost as active employees.	*Full-Time and Part-Time Employees* You may elect to continue coverage for the first three calendar months, paying the same monthly cost as active employees. After the first three calendar months, you may elect to continue coverage, paying 100% of the total monthly cost. Coverage may continue up to a total of 12 months.	*Full-Time and Part-Time Employees* You may elect to continue coverage for the first three calendar months, paying the same monthly cost as active employees. After the first three calendar months, you may elect to continue coverage, paying 100% of the total monthly cost. Coverage may continue up to a total of 24 months. You may elect to continue coverage throughout your **Emergency Active Military Leave**, paying the same monthly cost as active employees.

Benefit Coverage for Each Unpaid Leave Type		
Dental Plan *Vision Plan*	*Full-Time Employees* Continue up to 12 months. *Part-Time Employees* Continue up to 12 months if employee pays the same monthly cost as active employees.	*Full-Time Employees* Continue up to 24 months. Continue throughout your **Emergency Active Military Leave**. *Part-Time Employees* Continue coverage up to 24 months, paying the same monthly cost as active employees. Continue throughout your **Emergency Active Military Leave**, paying the same cost as active employees.
Basic Group Life Insurance Plan (GLIP) and Basic Accidental Death and Dismemberment (AD&D) Insurance	Continues up to 12 months and is Company-paid.	
Supplemental Life Insurance	Continues up to 12 months for most leave types, with employee paying back suspended premium costs upon return from leave.	
Dependent Life Insurance	Continues up to 12 months for most leave types, with employee paying back suspended premium costs upon return from leave.	
Voluntary Accidental Death and Dismemberment (AD&D) Insurance	Continues up to 12 months for most leave types, with employee paying back suspended premium costs upon return from leave.	
Employee Assistance Program (EAP)	Continues.	
Health Care Flexible Spending Account (HCFSA)	You must designate whether you wish to cancel or continue your monthly HCFSA contributions while you are on an unpaid leave. The Health Care Flexible Spending Account (HCFSA) Election While on Unpaid Leave of Absence Form, which is included in your leave of absence packet, must be completed and returned to the HR Service Center within 15 days of the onset of your leave. See the *Flexible Spending Accounts* section for more information.	
Dependent Care Flexible Spending Account (DCFSA)	Your participation in the DCFSA account ends at the end of the month in which your leave begins. Contributions will resume when you return to work if you return in the same calendar year. See the *Flexible Spending Accounts* section for more information.	
Health Account	Your participation continues as long as you are enrolled in the Health Account Plan (HAP). If you do not continue coverage in the HAP, you cannot participate in the Health Account. Additionally, expenses for health care services incurred during the period of the leave when you are not enrolled in the HAP are not eligible for reimbursement.	

Benefit Coverage for Each Unpaid Leave Type		
Vacation	You continue to accrue vacation at your normal accrual rate during the first 240 cumulative hours of leave, including the Emergency Active Military Leave, per calendar year. Additional time does not accrue if leave exceeds a cumulative total of 240 hours per calendar year. After 240 hours has been reached and if you remain on leave, additional time will not accrue until you return to work.	
Holidays	Not entitled to holiday pay.	
Sick Leave	*Full-Time Employees* Earned if employee works in the calendar year. *Part-Time Employees* A prorated amount of sick leave is earned if employee works in the calendar year.	
Retirement Plan	*Full-Time Employees* Continues; time on leave is credited as Company service. *Part-Time Employees* Credited service is earned for hours worked in the calendar year.	
Retirement Savings Plan	Contributions suspended; time on leave is credited as Company service.	Contributions suspended; time on leave is credited as Company service. May make up contributions and receive Company matching contributions upon return to work.
Employee Rates	Continues.	

Note: For medical dental and vision coverage, the Health Benefits Election Leave of Absence form must be completed and returned to the HR Service Center within 15 days of your unpaid leave date or you will be responsible to pay for any missed premiums.

Military Leaves

Special rules regarding benefits and pay apply to Emergency Active Military Leave. Please refer to "Leaves of Absence" in the *Time Off and Leaves* section.

Step Two — Take Action

Take the actions described in the following table to make sure you have the benefits you need.

What to Do	For Information and Assistance
Initiating a Leave of Absence ▪ A Leave of Absence must be initiated through the Company's Leave Administrator. Appropriate documentation must be submitted to your supervisor and/or the Leave Administrator for approval. Thirty days' advance notice is required when the leave is "foreseeable."	▪ "Leaves of Absence" in the *Time Off and Leaves* section

What to Do	For Information and Assistance
Review and return applicable forms ▪ Review your Leave of Absence Package for forms to return to your supervisor, the Company's Leave Administrator and/or the HR Service Center.	▪ Contact the Company's Leave Administrator if you have questions on the contents of your Leave of Absence Package and review "Leaves of Absence" in the *Time Off and Leaves* section. ▪ If you have any questions about your benefits while on a Leave of Absence, call the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Benefit Changes While on Unpaid Leave

While on leave, if you are in the HAP administered by KPIC, you may change HAP claims administrators if you move to an area where Kaiser Permanente is no longer available or if you qualify for a HIPAA special enrollment period. If you move, you must notify the HR Service Center within 31 days of the move.

If you are on a leave of absence, you may make certain changes during Open Enrollment, and the elections you make will become effective on January 1 (note: changes to life insurance coverage may not take effect until you are once again considered active at work — see the *Life and Accident Insurance Plans* section of this Handbook). Employees on a leave of absence will be notified of the Open Enrollment period and provided with Open Enrollment materials. For information on Open Enrollment while on a leave of absence, you can access a copy of the most recent Open Enrollment materials online at **www.mypgebenefits.com**, or you can request a copy by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

If you return to work before the end of the year in which your leave began, your current elections, including any suspended DCFSA elections (but excluding any suspended HCFSA elections), will automatically resume effective the first day of the month after your return to work. DCFSA contributions, if applicable, will be taken at the same monthly rate as before your leave, unless you made changes due to an eligible change-in-status event. DCFSA expenses for services incurred during your unpaid leave will not be eligible for reimbursement.

If you did not elect to continue your HCFSA during your leave and you wish to reinstate your participation in the HCFSA when you return to work, you must call the HR Service Center within 31 days of your return to work. You may either elect to reinstate your original monthly amount or your original annual goal. HCFSA expenses for services incurred during your unpaid leave will not be eligible for reimbursement. If you do not call within 31 days, you will not be enrolled in this account for the remainder of the year.

Benefits Changes Effective January 1 While Still on Unpaid Leave in a New Year

Any election you make during the Open Enrollment period will become effective January 1 of the next year.

If you do not make changes during the Open Enrollment period, you will continue with the same HAP claims administrator (or the alternative HAP claims administrator indicated on your Enrollment Worksheet if your HAP claims administrator is no longer available due to a move), and dental and vision coverage with the same dependents, effective January 1 of the following year. In addition, if you do not actively enroll during Open Enrollment, you will not be able to participate in the HCFSA. You are not eligible to elect DCFSA during Open Enrollment when you are on leave.

When you return to work in the following year, you will receive another enrollment packet. You can change your elections for the remainder of the new year. Coverage will take effect the first of the month following receipt of your elections, provided they are received by the HR Service Center within 31 days of your return to work. At that time, you may also add any Eligible Dependents attained during your leave. In addition, you will be able to elect HCFSA and DCFSA.

If you do not make elections for yourself and your dependents within 31 days of your return to work, you will have the same coverage you elected during Open Enrollment (or the default coverage described in the Open Enrollment materials). You will not be able to participate in the HCFSA or DCFSA.

You Leave PG&E

Step One — Understand Your Options

If you terminate employment with the Company, your coverage under most Plans ends, but you may have options to continue or convert your coverage.

Things to Consider	See...
What will happen to your medical, dental and vision coverage, flexible spending account(s), and Health Account participation if you leave the Company? Medical, dental and vision coverage end on the last day of the month in which your employment ends. You may continue your PG&E health care coverage for up to 18 months for yourself and your eligible family member's under a federal law called COBRA (certain coverages may also be continued for a domestic partner under a COBRA equivalent). If you have a balance remaining in your Health Care Flexible Spending Account, provided that you have elected to continue that account under COBRA, you may be eligible to continue receiving reimbursements for eligible expenses until the end of the calendar year in which your employment terminates. If you have a balance remaining in your Dependent Care Flexible Spending Account, you can only submit expenses that were incurred on or before the last day of the month of your termination, and you will forfeit any balance for which you do not submit timely requests for reimbursement of eligible expenses. If you have a Health Account because you were enrolled in the Health Account Plan (HAP), you will lose eligibility and will forfeit any balances in the account. Exceptions to forfeiting your Health Account are: continuing HAP coverage through COBRA; being eligible for retiree medical at retirement; going on Long-Term Disability; or re-enrolling in the HAP as an active employee in the same calendar year (i.e. you are re-hired in the same calendar year), at which time your Health Account balance will be reinstated.	▪ "When Coverage Ends" and "Continuing Coverage Under COBRA" in the *Health Care Participation* section ▪ "If You Retire or Leave the Company" in the *Flexible Spending Accounts* section
Can you continue your Group Life and AD&D Insurance if you leave the Company? You can convert your Group Life Insurance coverage to an individual policy directly with the insurance company if you request the change within 31 days of your coverage ending. You do not have to provide evidence of insurability (proof of good health) during this 31-day period. You cannot convert your AD&D coverage.	▪ "Converting Your Coverage to an Individual Policy" in the *Life and Accident Insurance Plans* section

Things to Consider	See...
Are you entitled to a pension benefit? If you have a vested benefit in the Pacific Gas and Electric Company Retirement Plan, you are eligible for a benefit under that plan according to the plan's rules. You can elect to begin receiving your Final Pay benefits beginning at age 55 or any time thereafter. If you have a Cash Balance Pension, you can elect to receive either the full balance of your cash balance account in a single lump-sum payment, or an actuarially equivalent monthly annuity for your lifetime. You can elect to receive your vested cash balance benefit at any time after your employment ends.	▪ "If You Leave the Company with a Vested Benefit and Want to Start Your Pension" in the *Retirement Plan — Final Pay Pension Benefit* subsection and "If You Leave the Company" in the *Retirement Plan — Cash Balance Pension Benefit* subsection of the *Retirement Benefits* section for more information
What can you do with your RSP balance? If you have a balance in an RSP account of at least $5,000, you may choose to leave the balance in the RSP until a later date of your choosing. Regardless of the size of your balance, you may take a distribution from the RSP. Your distribution can be a rollover to another employer plan (if allowable under that plan), a rollover to an individual retirement account, or as a direct payment to you in cash (subject to tax withholding and penalties). NOTE: If you leave PG&E before your 55th birthday and choose to keep your balance in the RSP, you'll be charged a quarterly administrative fee as long as you remain in the plan. The administrative fee as of 2014 is $15.25 per quarter. This fee does not apply to active employees or to employees who retire from PG&E (you are age 55 or older when your PG&E employment ends).	▪ "Withdrawal Options if You Leave PG&E" and "Distributions After Your Employment Has Ended" in the "Retirement Savings Plan" section of the *Retirement Benefits* section
Do you have unused vacation? If you terminate employment with the Company, you will be paid any earned but unused vacation.	▪ "Vacation Pay Upon Termination" in the *Time Off and Leaves* section

Step Two — Take Action

If you leave the Company, you need to make decisions about continuing coverage under certain Plans.

What to Do	For Information and Assistance
No later than 31 days after your PG&E coverage ends	
To convert to an individual life insurance policy ▪ If you and your family members want to convert any life insurance coverage that is eligible for conversion to an individual policy, you must continue to make payments directly to the insurance company.	▪ To apply for an individual policy, contact MetAdvice Line at 877-275-6387, Option 1.

What to Do	For Information and Assistance
Within 60 days after the later of the date your PG&E coverage ends or the date you receive a COBRA election notice	
Send the COBRA election notice and supporting documentation to the COBRA Administrator ▪ To continue PG&E health coverage under COBRA (or a COBRA coverage equivalent), you'll need to return the COBRA election notice, payment, and any supporting documentation to the COBRA Administrator within 60 days after the date your PG&E coverage ends or the date of the COBRA election notice, whichever is later. Qualified beneficiaries have 45 days from the date of their election to pay their initial premium payments.	▪ Information regarding COBRA continuation of coverage will be provided by the COBRA Administrator. ▪ See "Continuing Coverage Under COBRA" in the *Health Care Participation* section for the rules and time frames that apply, as well as the names and contact information of the COBRA Administrator.
Any time after you leave PG&E	
Contact Fidelity for RSP distribution options To remove funds from your RSP account, either as a rollover or as a cash payment, you'll need to return distribution forms to Fidelity. If you have a balance of at least $5,000, you may choose to leave your balance in the RSP — in this case, no action is necessary. NOTE: If you leave PG&E before your 55th birthday and choose to keep your balance in the RSP, you'll be charged a quarterly administrative fee as long as you remain in the plan. The fee for 2014 is $15.25 per quarter. This fee does not apply to active employees or to employees who retire from PG&E.	▪ You'll receive a termination kit from Fidelity after 30 days have passed from your last day of work. ▪ See the RSP Summary Plan Description at Fidelity NetBenefits at www.401k.com or call the PG&E RSP Service Center at 877-PGE-401K for information about distributions from the plan.

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You Retire

The Company's retirement benefits help you prepare for the future. In addition to your accrued pension and Retirement Savings Plan benefits, if you retire after age 55, you may be eligible for retiree medical coverage, post-retirement life insurance coverage, as well as retiree discounts on gas and electricity.

Step One — Understand Your Options

Things to Consider	See…
Planning ahead is a must. Are you prepared? Review the description of PG&E's retirement plans for an overview on how to participate, how the plans work, and when benefits are payable.	▪ The "Retirement Plan" in the *Retirement Benefits* section ▪ The "Final Pay" and the "Cash Balance" in the *Retirement Benefits* section ▪ The "Retirement Savings Plan" in the *Retirement Benefits* section ▪ "Retiree Medical Coverage" in the *Retirement Benefits* section ▪ "If You Retire" under "What Happens…" in the *Life and Accident Insurance Plans* section

Things to Consider	See…
How soon do you have to enroll for retiree medical coverage? If you are eligible for retiree medical coverage, you must complete the Retiree Medical Election Form and return it to the HRSC at least 30 days before your retirement date. If the form is not received by the HR Service Center on time, your medical coverage will be cancelled as of your retirement date, and you must wait until the next Open Enrollment period to enroll in a Company-sponsored retiree medical plan.	▪ "Retiree Medical Coverage" in the *Retirement Benefits* section
How or must you enroll each year for coverage under the retiree medical plan? If you waive coverage or miss the enrollment deadline when you retire, you will not be able to enroll yourself or Eligible Dependents for coverage until the next Open Enrollment period. You must notify the HR Service Center by September 1 in order to receive an Open Enrollment package for the following plan year. As a retiree, you may only make changes on a mid-year basis if you are already enrolled in a medical plan and have a change-in-status event that allows for a change.	▪ "Changing Your Coverage" in the *Retirement Benefits* section ▪ "Annual Open Enrollment" in the *Health Care Participation* section
What will happen to your Health Account? If you are eligible for PG&E-sponsored medical coverage as a retiree–even if you waive retiree medical coverage when you retire and later enroll — you can keep your unused Health Account balance. You won't receive new credits in your Health Account after you retire because the HAP is not available to retirees. Be sure to submit eligible claims and supporting documentation to the Your Spending Account (YSA), the third-party Health Account administrator.	▪ "If You Retire" in the *Health Account* section

Gas and Electric Discount

Your discount continues as a retiree, but you have to re-enroll. It will continue after your death, for six more billings from the time of your death as long as you would otherwise be eligible. Refer to the "Retiree Discount" in the *Other Benefits* section of the Summary of Benefits Handbook for Retirees and Surviving Dependents for more details, including contact information.

Step Two — Take Action

Take the actions described in the following table to make sure you have the benefits you and your dependents need.

What to Do	For Information and Assistance
Request a Retirement Package in writing at least 90 days before the date you want to retire.	
For pension benefits and retiree medical coverage, complete and return the documents provided in the Retirement Package at least 30 days before you retire. You may choose to start your pension and medical benefits at the same time or separately. You're not required to start your pension to elect medical coverage, and you're not required to elect medical coverage to receive your pension. Review the Summary of Benefits Handbook for Retirees online in the **Benefit Plan Documents** section of the PG&E@Work intranet.	▪ Contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363. ▪ Request a copy of the Summary of Benefits Handbook for Retirees by sending an email to the HR Service Center at hrbenefitsquestions@exchange.pge.com.

What to Do	For Information and Assistance
If you want to enroll in retiree medical coverage but did not do so at retirement, you may add yourself or your Eligible Dependents during the next Open Enrollment period. If you are eligible for retiree medical but do not enroll at least 30 days before your retirement, you will not be able to enroll yourself or Eligible Dependents in the retiree medical plan until the next Open Enrollment period. You must notify the HR Service Center by September 1 in order to receive an Open Enrollment package for the following plan year.	
Sign up for other programs for which you are eligible in retirement. You continue to be eligible for the Employee Discount but you must re-enroll as a retiree.	▪ See "Employee Discount" in the *Work/Life Benefits* section
Contact Fidelity for RSP distribution options To withdraw funds from your RSP account, either as a rollover or as a cash payment, you'll need to return distribution forms to Fidelity. If you have a balance of at least $5,000, you may choose to leave your balance in the RSP — in this case, no action is necessary.	▪ Log on to Fidelity NetBenefits at www.401k.com or call the PG&E RSP Service Center at 877-PGE-410K.

Family Events

The following subsections describe how your benefits are affected when certain family events occur and what actions you may need to take:

- If You Get Married or Enter into a Registered Domestic Partnership,
- If You Become Divorced or Legally Separated, or End a Registered Domestic Partnership,
- If You Have or Adopt a Child or Become a Foster Parent or a Legal Guardian,
- If You Move,
- If You Lose Other Coverage, After Declining Company Coverage, and
- If Your Spouse or Registered Domestic Partner Retires.

Don't Miss the Deadline!

Most of the family events described here allow you to change coverage because they qualify as change-in-status events. With change-in-status events, there is typically a 31-day deadline (180 days for births and adoptions) to submit your election changes. If you miss the deadline, you will not be able to change your coverage until the next annual open enrollment period.

You Get Married or Enter into a Registered Domestic Partnership

If you get married or enter into a registered domestic partnership, you may be eligible to make changes to your coverage. For more details, see "Change-in-Status Events" on page 82 and see "HIPAA Special Enrollment Periods" in the *Health Care Participation* section.

Under the Health Account Plan (HAP), you must notify the HR Service Center of any changes within 31 days, or you will not be able to enroll, change or cancel coverage. No late enrollments will be accepted.

31-Day Deadline!

There is 31-day deadline for submitting your change elections. If you miss the deadline, you may not be able to change your coverage until the next annual enrollment period.

Life changes like marriage or a newly registered domestic partnership are important events that require you to review your retirement savings goals. Review the tools available from Fidelity and Financial Engines to ensure you're saving enough for retirement and to find out how to balance saving for retirement with your other financial goals.

It's also important to review your beneficiary designations when you have a significant life change. Make sure that you've designated the people you wish to protect in the event of an unforeseen accident.

Step One — Understand Your Options

You can make certain adjustments to your benefits if you get married or begin a registered domestic partner relationship. Consider the following:

Things to Consider	See...
Is your spouse or registered domestic partner also a PG&E employee? If you and your spouse or registered domestic partner are both Management or A&T employees, then you may choose to enroll your spouse or registered domestic partner as your family member, or vice versa. Or you may each enroll in individual coverage as a Company employee. Keep in mind that you cannot be covered as both a family member and as an employee.	▪ "Eligible Dependents" in the *Health Care Participation* section ▪ "Change-in-Status Events" on page 82

Things to Consider	See...
Is your spouse or registered domestic partner eligible for health benefits or insurance coverage from another source? If so, think about your and your spouse's (or registered domestic partner's) enrollment choices. Consider the most effective coverage choices for you. In addition, for domestic partners, there is the added cost of imputed income. The PG&E HAP through Anthem Blue Cross will coordinate with medical plans, however, in most cases it may not be cost-effective to be covered by more than one medical plan. If you have coverage elsewhere, review PG&E's coordination of benefits provisions before enrolling in the PG&E Plan. The KPIC HAP does not coordinate with other medical plans. You have 31 days from the date you marry or establish a registered domestic partnership to enroll yourself or any other eligible family members in Company-sponsored health care coverage, regardless of health status.	▪ "If You Have Other Coverage" in the *Health Care Participation* section
Does your spouse or registered domestic partner have family members? They may be eligible for PG&E benefits once you are married or begin your domestic partnership.	▪ "Eligible Dependents" in the *Health Care Participation* section
Is your spouse contributing to a Flexible Spending Account? If so, you may want to adjust your own contributions. For example, a Dependent Care Flexible Spending Account (DCFSA) has contribution limits for married couples. If not, you may want to enroll and begin contributing to the Company-sponsored HCFSA or DCFSA if you expect to have more expenses with your new family member(s). Note: Your registered domestic partner and his or her child(ren) must meet the plan's definition of a tax dependent under the Internal Revenue Code in order to participate in any Flexible Spending Account arrangement. Please see "Tax Implications of Coverage for Your Registered Domestic Partner, or Children of Your Registered Domestic Partner" under "Eligible Dependents" in the *Health Care Participation* section for more details.	▪ "Flexible Spending Accounts" in the *Flexible Spending Accounts* section

Things to Consider	See…
Do you need to increase the amount of your life and/or AD&D insurance coverage or change your beneficiary under these Plans? If you're not already covered by Supplemental Life Insurance and/or Voluntary AD&D Insurance, you may want to consider enrolling. If you are enrolled, you may wish to review your coverage amount. In addition, you may want to consider enrolling your spouse and eligible dependents for Dependent Life Insurance coverage.	▪ "Group Life Insurance," "Changing the Level of Your Coverage," and "How Your Benefit Is Paid" in the *Life and Accident Insurance Plans* section
Do you need to update your beneficiary designations? Be sure to review and update beneficiary designations for your life insurance coverage, as well as your Retirement Plan (pension) and Retirement Savings Plan (401(k)) to ensure that if you die, the death benefits will go to the person(s) you want to receive them.	▪ "How Your Benefit is Paid" in the *Life and Accident Insurance Plans* section ▪ "Beneficiary Designation" in the *Life and Accident Insurance Plans* section ▪ "If You Die Before You Retire" in the "Final Pay Pension" section of the *Retirement Benefits* section ▪ The "Retirement Savings Plan" in the *Retirement Benefits* section

Step Two — Take Action

After you've decided on the benefits that meet your or your family's changing needs, follow the appropriate steps in the following chart, based on your choices.

What to Do	For Information and Assistance
No later than 31 days after your marital or registered domestic partnership status change	
Medical, Dental and Vision Plans ▪ If you're already enrolled, you may enroll your spouse or registered domestic partner and any eligible family members in the same option (subject to certain limitations for individuals who are Medicare-eligible). ▪ If you're not already enrolled, you can enroll yourself and any eligible family members in the option in which you are enrolling (subject to certain limitations for individuals who are Medicare-eligible). ▪ Both same-sex and opposite-sex registered domestic partners of employees are eligible for coverage under the Company's medical, dental and vision care plans. **Flexible Spending Accounts** ▪ Begin making contributions or change the amount you contribute to the Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account. **Note:** Special tax regulations apply to Health Care Flexible Spending Accounts and registered domestic partners. Consult your tax advisor regarding what is permissible under current tax regulations.	▪ Email the HR Service Center at hrbenefitsquestions@exchange.pge.com, or contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363. ▪ See "Flexible Spending Account Limitations" in the *Flexible Spending Accounts* section ▪ See the *Medical Coverage for Participants on Long-Term Disability* section

What to Do	For Information and Assistance
As soon as possible:	
Review your beneficiary designations ▪ Review and update beneficiary designations for your Retirement Plan, Retirement Savings Plan and insurance coverage to ensure that if you die, benefits will go to the person(s) you want to receive them. ▪ Make sure that all required information (such as benefit percentages, names, addresses, etc.) is current and correct so that if you die, claims will be paid as quickly as possible to your designated beneficiary/beneficiaries.	▪ "How Your Benefit Is Paid" in the *Life and Accident Insurance Plans"* section ▪ "Beneficiary Designation" in the *Life and Accident Insurance Plans* section ▪ "If You Die Before You Retire" in the *Retirement Plan — Final Average Pay Pension Benefit* subsection and "If You Die Before You Retire" in the *Retirement Plan — Cash Balance Pension Benefit* subsection of the *Retirement Benefits* section ▪ The "Retirement Savings Plan" in the *Retirement Benefits* section

You Become Divorced or Legally Separated, or End a Registered Domestic Partnership

If you get divorced, legally separated or end a registered domestic partnership, you may be eligible to make changes to your coverage. For more details, see "Change-in-Status Events" on page 82 and see the "Loss of Other Coverage Provision" under "HIPAA Special Enrollment Periods" in the *Health Care Participation* section.

31-Day Deadline!

There is 31-day deadline for submitting your change elections. If you miss the deadline, you may not be able to change your coverage until the next annual enrollment period.

Under the Health Account Plan (administered by Anthem Blue Cross or Kaiser Permanente Insurance Company), you must notify the HR Service Center of the changes within 31 days, or you will not be able to enroll, change or cancel coverage. No late enrollments will be accepted. In addition, there are penalties for carrying Ineligible Dependents. Be sure to promptly drop dependents who are no longer your legal dependents, or you will be required to pay restitution to PG&E for the associated costs of carrying these Ineligible Dependents.

Step One — Understand Your Options

Getting a divorce, becoming legally separated, or ending a registered domestic partner relationship can affect your benefits. The following table outlines how your coverage is affected if any of these events occur.

Things to Consider	See...
Were you covered under your former spouse's or registered domestic partner's health insurance? If so, you may want to enroll in PG&E's Plan. If your former spouse or registered domestic partner is a PG&E employee and you were covered as his or her family member under the Medical, Dental or Vision Plans, you can enroll in the Medical, Dental or Vision Plans as a PG&E employee.	▪ "When Coverage Ends" and "Continuing Coverage Under COBRA" and the "Loss of Other Coverage Provision" under "HIPAA Special Enrollment Periods" in the *Health Care Participation* section

Things to Consider	See…
Was your former spouse or former registered domestic partner previously covered as your dependent? A former spouse or former registered domestic partner no longer meets the eligibility rules for PG&E-provided medical coverage, and must be removed from the medical plan within 31 days of divorce or termination of the registered domestic partnership. This is true even if a court orders you to provide coverage, because former spouses and registered domestic partners are ineligible dependents under PG&E's plan. Your former spouse or registered domestic partner may be eligible to apply for COBRA health care coverage (or a COBRA coverage equivalent) through PG&E.	▪ "Eligible Dependents," "When Coverage Ends" and "Continuing Coverage Under COBRA," in the *Health Care Participation* section ▪ "Qualified Medical Child Support Notices" in the *Health Care Participation* section
Do you or your former spouse or registered domestic partner have family members? If so, determine whether they'll be covered by your health care coverage or your former spouse's or domestic partner's coverage. Former step-children or children of a former registered domestic partner will no longer be eligible for PG&E-sponsored coverage with one exception: they will continue to be eligible if you have adopted them or they were born during the course of a registered domestic partnership. After a divorce or separation, your child(ren) might have court-ordered rights to health care coverage provided by you.	▪ "Ineligible Dependents" in the *Health Care Participation* section ▪ "Qualified Medical Child Support Notices" in the *Health Care Participation* section
Was your former spouse contributing to a Dependent Care Flexible Spending Account? If so, limits on married couples' contributions no longer apply. You may want to adjust your contributions.	▪ "Whose Expenses Are Eligible?" and "Setting Up Your Flexible Spending Accounts" in the *Flexible Spending Accounts* section
Do you want to name someone other than your former spouse or registered domestic partner as your beneficiary for your Life and Accident Insurance, Retirement Plan pre-retirement death benefit and/or Retirement Savings Plan account? If your former spouse or registered domestic partner was your beneficiary, he or she will continue as your beneficiary unless you designate a different beneficiary.	▪ "How Your Benefit Is Paid" in the *Life and Accident Insurance Plans* section ▪ "Beneficiary Designation" in the *Life and Accident Insurance Plans* section ▪ "If You Die Before You Retire" in the *Retirement Plan — Final Average Pay Pension Benefit* subsection and "If You Die Before You Retire" in the *Retirement Plan — Cash Balance Pension Benefit* subsection of the *Retirement Benefits* section ▪ The "Retirement Savings Plan" in the *Retirement Benefits* section

Things to Consider	See…
Do you have a Qualified Domestic Relations Order (QDRO) that specifies how certain benefits considered community property will be divided, or your obligation to provide benefit coverage to a former spouse or covered dependent? If so, you should submit a file-endorsed QDRO to PG&E for appropriate application to your benefit coverage. For detailed information about the effect of divorce on your benefits, you can request a copy of "Divorce Manual: A Guide for Benefits in the Event of a Divorce" as well as a sample QDRO from the HR Service Center	▪ Email the HR Service Center at hrbenefitsquestions@exchange.pge.com, or contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363. ▪ "If You Get Divorced" in the *What Happens…* section of *Retirement Plan – Final Pay Pension Benefit* ▪ "Qualified Domestic Relations Orders (QDRO)" in the *Retirement Savings Plan* section
Your former spouse or registered domestic partner may be eligible to apply for COBRA coverage (or a COBRA coverage equivalent) if his or her coverage would otherwise end because of the divorce or end of the domestic partnership. Notify the HR Service Center of the divorce, legal separation or end of the registered domestic partnership so that your former spouse or registered domestic partner can receive information about the available options.	▪ "When Coverage Ends," "Continuing Coverage Under COBRA," and the "Loss of Other Coverage Provision" under "HIPAA Special Enrollment Periods" in the *Health Care Participation* section

Step Two — Take Action

After you've decided on the benefits that meet your or your family's changing needs, follow the appropriate steps in the following chart, based on your choices.

What to Do	For Information and Assistance
No later than 31 days after your marital status change or termination of your registered domestic partnership	
Medical, Dental and Vision Plans ▪ Enroll yourself and/or eligible family members, if necessary. ▪ Cancel family member coverage for your former spouse or registered domestic partner. You may continue coverage for your own child(ren). If registered domestic partner coverage is terminated, coverage for the children of registered domestic partners will also be terminated unless you have adopted them or the children were born during the course of your registered domestic partnership. ▪ Understand how a Qualified Medical Child Support Order (QMCSO) can affect your benefits. **Health Care and Dependent Care Flexible Spending Accounts** ▪ Enroll, change the amount(s) you contribute or stop making contributions to the Health Care and/or Dependent Care Flexible Spending Accounts.	▪ For additional information on enrolling in the Plans, see and "Changing the Level of Your Coverage" in the *Life and Accident Insurance Plans* section. ▪ "Eligible Dependents" in the *Health Care Participation* section ▪ "Qualified Medical Child Support Orders" under "Eligible Dependents" in the *Health Care Participation* section

What to Do	For Information and Assistance
If Your Spouse or Registered Domestic Partner Is Losing Medical, Dental and/or Vision Coverage ▪ You or your former spouse or registered domestic partner must notify PG&E if he or she is losing health coverage as a result of the divorce or end of the partnership and wishes to continue coverage through COBRA (or a COBRA coverage equivalent that may apply to your former registered domestic partner). ▪ PG&E will then contact the COBRA Administrator, who will mail the COBRA notice and other information to your former spouse (or a similar notice about the COBRA coverage equivalent to your former registered domestic partner). ▪ To continue PG&E health coverage under COBRA (or a COBRA coverage equivalent), your former spouse or registered domestic partner must return the COBRA election notice, payment, and any supporting documentation to the COBRA Administrator within 60 days after either the date on which his or her PG&E coverage ends or the date of the COBRA election notice, whichever is later. ▪ Note: Failure to provide notice, make payment, or elect coverage within the required time frames means that COBRA coverage (or a COBRA coverage equivalent) will not be available to eligible beneficiaries.	▪ "Continuing Coverage Under COBRA" in the *Health Care Participation* section ▪ You can send an email to the HR Service Center at hrbenefitsquestions@exchange.pge.com, or you can contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-HELP (415-973-4357) or toll-free at 800-788-2363.
As soon as possible	
Review Your Beneficiary Designations and Consider Canceling Unnecessary Insurance Coverage ▪ Review and update beneficiary designations for your insurance coverages to ensure that if you die, death benefits will go to the person(s) you want to receive them. ▪ Make sure that all required information (such as benefit percentages, names, addresses, etc.) is current and correct so that if you die, claims can be paid as quickly as possible to your designated beneficiary/beneficiaries.	▪ "How Your Benefit Is Paid" in the *Life and Accident Insurance Plans* section ▪ "Beneficiary Designation" in the *Life and Accident Insurance Plans* section ▪ "If You Die Before You Retire" in the *Retirement Plan — Final Average Pay Pension Benefit* subsection and "If You Die Before You Retire" in the *Retirement Plan — Cash Balance Pension Benefit* subsection of the *Retirement Benefits* section ▪ The "Retirement Savings Plan" in the *Retirement Benefits* section

You Have or Adopt a Child or Become a Foster Parent or a Legal Guardian

When a new child joins your family, you will usually be able to make changes to your coverage. For more details, see "Change-in-Status Events" on page 82 and see the "HIPAA Special Enrollment Periods" in the *Health Care Participation* section.

Enroll Your Child Within 180 Days!

To avoid uncovered expenses, you must enroll your newborn or adopted child promptly by notifying the HR Service Center within 180 days of your child's birth or adoption.

Under the Health Account Plan (HAP), you must notify the HR Service Center within 180 days from the date on which your child is born or placed with you for adoption or within 31 days from the date on which you become the child's legal guardian or the child is placed with you for foster care. If you enroll the child during the appropriate timeframe, coverage will be retroactive to the date of the change-in-status event. If you do not contact the HR Service Center within the designated period, your new child will not have any coverage during this time. No late enrollments will be accepted.

Life changes like having new children are important events that require you to review your retirement savings goals. Review the tools available from Fidelity and Financial Engines to ensure you're saving enough for retirement and find out how to balance saving for retirement with your other financial goals.

Step One — Understand Your Options

When you have a baby or otherwise gain a child, the following can affect how you use your benefits before, during and after the child's arrival. You'll want to be sure that you get the full value from your PG&E benefits. Consider the following:

Things to Consider	See...
Is your spouse or registered domestic partner also a PG&E employee? If one spouse or registered domestic partner is enrolled in benefits as a Company employee, he or she can enroll the child as a family member (or you can do so). If each spouse or registered domestic partner is enrolled as a Company employee, either one — but not both — may cover the child.	▪ "Eligible Dependents" in the *Health Care Participation* section
Does your spouse or registered domestic partner have health benefits or insurance coverage from another source that could cover the child? If so, think about the most effective coverage choices for you (in terms of both the benefits available and your total cost for coverage — that is, your annual contributions plus the amount you pay when you receive services). You have 180 days (for births or adoptions) to enroll yourself and your eligible family members, regardless of health status. In addition, you have 31 days to enroll a new foster child or child for whom you have been appointed legal guardianship.	▪ "If You Have Other Coverage" in the *Health Care Participation* section
How much time off will you and/or your spouse or domestic partner need after the child's birth or adoption? Your unique situation will determine how much time off is necessary to meet your needs. You may be able to take leave under the Family and Medical Leave Act (FMLA) or similar state leave laws or Company leave programs. Company-provided time off, such as vacation time, may run concurrently with your FMLA or state leave. Contact the Company's leave administrator for more information on FMLA or other leave options.	▪ "Personal Leave of Absence" in the *Time Off and Leaves* section

Things to Consider	See…
Who will care for the child if both you and your spouse (or registered domestic partner) return to work? A Dependent Care Flexible Spending Account (through PG&E and/or your spouse's or domestic partner's employer) can reduce your taxes, making it easier for you to pay for dependent day care. Note: Special tax regulations apply to flexible spending accounts (like the DCFSA) and registered domestic partners. Consult your tax advisor regarding what is permissible under current tax regulations.	▪ "Dependent Care Flexible Spending Account (DCFSA)" in the *Flexible Spending Accounts* section ▪ "Tax Implications of Coverage for Your Registered Domestic Partner, or Children of Your Registered Domestic Partner" under "Eligible Dependents" in the *Health Care Participation* section ▪ "PG&E Children's Center" in the *Work/Life Benefits* section
Do you need to increase your life insurance coverage?	▪ "Changing the Level of Your Coverage" in the *Life and Accident Insurance Plans* section

Step Two — Take Action

After you've decided on the benefits that meet your family's changing needs, follow the appropriate steps in the following chart, based on your choices.

What to Do	For Information and Assistance
Before the baby arrives	
Obtain information ▪ Research providers. ▪ Get information about pregnancy and childbirth, as well as additional support for high-risk pregnancies, at no cost to you, through your medical plan. ▪ If you are adopting a child, find out about adoption resources.	▪ Email the HR Service Center at hrbenefitsquestions@exchange.pge.com, or contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363. ▪ "Adoption Expense Reimbursement Program" in the *Work/Life Benefits* section
Confirm your benefits ▪ Confirm the benefits available to you during and after your pregnancy, and find out how much leave you can take.	▪ Review the appropriate section that describes your medical plan in this handbook ▪ Medical and/or Personal Leaves of Absence in the *Time Off and Leaves* section
Make arrangements ▪ Confirm your plans, if any, to take time off from work under the Family and Medical Leave Act (FMLA), similar state leave laws or Company leave programs, and make arrangements for a leave of absence.	▪ Contact your supervisor and the Company's Leave Administrator. The Leave Administrator can be reached at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

What to Do	For Information and Assistance
No later than 180 days after the baby is born or placed with you for adoption	
Medical, Dental and Vision Plans ▪ Enroll your new child in the Medical, Dental and Vision Plans in which you are enrolled. ▫ Note: You must enroll your new child even if you have already elected family coverage. Coverage for a new child will not occur automatically. ▪ If you are not already enrolled, you may also enroll yourself and other eligible family members. **Health Care and Dependent Care Flexible Spending Accounts** ▪ Consider changing or beginning contributions to the Health Care and Dependent Care Flexible Spending Accounts to save before-tax dollars on the additional expenses you will incur. ▫ Note: If you enroll in the Health Care and/or Dependent Care Flexible Spending Accounts following a qualified change of status, the amounts you contribute are available only for charges incurred on or after the event date, not before. ▫ Note: Special tax regulations apply to FSAs (like HCFSAs and DCFSAs) and registered domestic partners and their children. Consult your tax advisor for what is permissible under current tax regulations.	▪ "Eligible Dependents" in the *Health Care Participation* section ▪ "How Health Care Flexible Spending Accounts (HCFSAs) and Dependent Care Flexible Spending Accounts (DCFSAs) Work" in the *Flexible Spending Accounts* section
As soon as possible	
Review your beneficiary designations ▪ Review and update beneficiary designations for your Retirement Plan, Retirement Savings Plan and insurance coverages to ensure that if you die, your death benefits will go to the person(s) you want to receive them. ▪ Make sure that all required information (such as benefit percentages, names, addresses, etc.) is current and correct so that if you die, claims can be paid as quickly as possible to your designated beneficiary/beneficiaries.	▪ "How Your Benefit Is Paid" in the *Life and Accident Insurance Plans* section ▪ "Beneficiary Designation" in the *Life and Accident Insurance Plans* section ▪ "If You Die Before You Retire" in the *Retirement Plan — Final Average Pay Pension Benefit* subsection and "If You Die Before You Retire" in the *Retirement Plan — Cash Balance Pension Benefit* subsection of the *Retirement Benefits* section ▪ The "Retirement Savings Plan" in the *Retirement Benefits* section

What to Do	For Information and Assistance
Get financial assistance with an adoption ▪ Contact the HR Service Center for information regarding reimbursement of eligible adoption expenses.	▪ "Adoption Expense Reimbursement Program" in the *Work/Life Benefits* section ▪ Email the HR Service Center at hrbenefitsquestions@exchange.pge.com, or contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.
Consider changing your life and/or AD&D insurance coverage	▪ "Changing the Level of Your Coverage" in the *Life and Accident Insurance Plans* section.
Review your retirement savings goals Contact Fidelity or Financial Engines to ensure you're saving enough for retirement, and to use tools to help adjust your budget and manage your savings needs for all of your financial goals.	▪ Log on to Fidelity NetBenefits at www.401k.com and access the "Tools and Learning" section to review and use budgeting and savings resources. ▪ Log on to Fidelity NetBenefits at www.401k.com and click the Financial Engines link to review savings and investment advice for the RSP, and all of your retirement accounts if you wish.

You Move

If you are currently enrolled in the Kaiser Permanente Insurance Company-administered Health Account Plan (HAP), which bases eligibility on your home ZIP Code, and you subsequently move your residence to a ZIP Code outside of the Kaiser Permanente service area, you will have the option to switch to the HAP administered by Anthem Blue Cross or to waive medical plan coverage.

Moving may make you eligible to make changes to your coverage under a HIPAA Special Enrollment Period. For more details, see "HIPAA Special Enrollment Periods" in the *Health Care Participation* section.

Alert the Service Center Within 31 Days!

Be sure to notify the HR Service Center of your change of address within 31 days of your move. If you notify the Company of your move within 31 days, enrollment with your new HAP claims administrator, if applicable, will take effect on the first day of the month following your notification. If you do not notify the Company within 31 days, you may not be eligible for services under your health plan, or you may receive lower benefits.

Changing Your Address

You may update your home address and phone number by using the Company's intranet. To update your changes, go to PG&E@Work For Me **(located under "Tools" from the homepage) > About Me > My Personal Information > Home Address** and simply click "Change Address."

You may also update your address by contacting the HR Service Center. Your new address will be forwarded to the plan administrators, insurance carriers and other benefit administrators, if applicable.

You Lose Other Coverage, After Declining Company Coverage

If you declined PG&E coverage because you had other coverage, and you then lose that other coverage, you may be eligible to make changes to your coverage under a HIPAA Special Enrollment Period. For more details, see "Loss of Other Coverage Provisions" under "HIPAA Special Enrollment Periods" in the *Health Care Participation* section.

Your Spouse or Registered Domestic Partner Retires

Step One — Understand Your Options

Under certain circumstances, you may elect health care coverage (such as medical, dental, vision and flexible spending accounts coverage) if your spouse or registered domestic partner retires.

Things to Consider	See...
Were you covered under his/her employer's benefit plans or was he or she covered under PG&E's plans? A HIPAA Special Enrollment Period may be available to you and your Eligible Dependents if you lose other coverage, provided that you previously declined coverage under a PG&E-sponsored health care plan (medical, dental or vision) because you had such other coverage.	▪ "HIPAA Special Enrollment Periods" in the *Health Care Participation* section

Step Two — Take Action

What to Do	For Information and Assistance
Enroll within 31 days of losing coverage.	
Request enrollment Request enrollment by contacting the HR Service Center within 31 days of losing coverage elsewhere.	▪ You can send an email to the HR Service Center at hrbenefitsquestions@exchange.pge.com, or you can contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Health Events

The following subsections describe how your benefits are affected when certain health events occur and what actions you may need to take:

- If You Are Injured or Sick and Absent from Work,
- If You Are Disabled Long-Term and Go on LTD, and
- If You Become Terminally Ill or Die While an Active Employee.

You Are Injured or Sick and Absent from Work

If you are injured or sick and unable to come to work, follow the procedures for notifying the Company that you will be absent. If you believe your injury may be covered by Workers' Compensation, follow those notification procedures as well.

Step One — Understand Your Options

Things to Consider	See…
Be sure to understand the income replacement provided if you remain absent, and how a prolonged absence can affect your benefits	▪ The *Sick Leave & Disability* section
Understand what happens while you are on Workers' Compensation Your participation in the benefit plans generally continues while you are on Workers' Compensation. An exception is participating in the Health Care Flexible Spending Account.	▪ "If You Are on Long-Term Disability or Workers' Compensation" in the *Flexible Spending Accounts* section
What happens if your Workers' Compensation benefits end and you go on LTD or an unpaid leave status	▪ "You Are Disabled Long-Term and Go on LTD" and "You Take an Unpaid Leave of Absence" in the *Sick Leave & Disability* section

Step Two — Take Action

What to Do	For Information and Assistance
In an emergency	
In case of a work-related emergency, go to the nearest emergency medical facility and, as soon as possible, contact the Safety and Workers' Compensation HELPLINE (HELPLINE) at 415-973-8700 (outside) or Company number 8-223-8700, and select Option 2	▪ "Procedures in the Event of an Industrial Injury or Illness" in the *Sick Leave & Disability* section

What to Do	For Information and Assistance
As soon as you know you will not be able to come to work	
Report your work-related absence	▪ Every industrial injury or illness must be reported to your supervisor. ▪ If an employee has a work-related incident, he or she should notify his or her supervisor and then call the 24/7 Nurse Report Line at (888) 449-7787. ▪ See "Procedures in the Event of an Industrial Injury or Illness" in the *Sick Leave & Disability* section. ▪ Contact the Company's Leave Administrator. The Leave Administrator can be reached at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.
Report your non-work-related absence	▪ Contact your supervisor and the Company's Leave Administrator. The Leave Administrator can be reached at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363. ▪ See "Medical Leave of Absence" in the *Time Off and Leaves* section.
While you are absent	
During your absence stay in touch with your supervisor and the Company's Leave Administrator or your Workers' Compensation representative, whichever is applicable (note: FMLA and CFRA run concurrently with your Workers' Compensation absence).	▪ See "Medical Leave of Absence" in the *Time Off and Leaves* section. ▪ See "Procedures in the Event of an Industrial Injury or Illness" in the *Sick Leave & Disability* section.

You Are Disabled Long-Term and Go on LTD

If you qualify to go on Long-Term Disability (LTD) benefits, your medical coverage will continue; however, you will need to select a new medical plan such as the Anthem Blue Cross NAP or CAP, or the Kaiser Permanente Insurance Company EPO or Kaiser Senior Advantage plan (the Health Account Plan (HAP) is not available to employees receiving LTD), and you will be responsible for making any required contributions. While you are on LTD, you can submit claims to your Health Account until you exhaust any unused balance. However, you will not be eligible to receive the annual Health Account credits at the beginning of the plan year. As long as you remain on LTD, you cannot earn extra credits by taking the annual health screening or participating in the tobacco-free program.

Whether you return to work in the same calendar or a subsequent year, if you resume your active status as an employee and enroll in HAP coverage, you will receive Health Account credits at either the single or family level of coverage if you have not already received that year's credits. You can also earn extra credits by taking the annual health screening and/or participating in the tobacco-free program.

Dental, Vision, Basic and Supplemental Life Insurance, and Basic AD&D Life Insurance coverages will continue. You are responsible for any required premium payments as specified in the applicable health care plan. For Dependent Life Insurance and Voluntary AD&D coverage, your coverage for those benefits will remain in effect as long as you remit payment. Your participation in the Health Care Flexible Spending Account (HCFSA) and/or the Dependent Care Flexible Spending Account (DCFSA) will end. During the annual Open Enrollment period, you may not elect to contribute to the HCFSA or DCFSA.

Your eligibility to participate in the Retirement Savings Plan continues while you are on LTD. See the *Retirement Savings Plan* section. You can also visit the Fidelity Investment's website at www.401k.com, or call the Fidelity RSP Service Center at 877-PGE-401K (877-743-4015) for more information.

Step One — Understand Your Options

When a non-occupational illness or injury prevents you from working for an extended period of time, it's important to contact the Company's Leave Administrator, your manager or immediate supervisor immediately to let them know you will be absent from work for an extended period. Salary continuation or disability benefits may be available to you under the Company's Sick Leave and/or Disability program.

In addition, consider the following:

Things to Consider	See…
Do you know the income resources that are available? You may be required to use any available sick leave. You may be eligible to use available vacation days or to apply for State Disability insurance, Long-Term Disability benefits, Worker's Compensation (if your disability is work-related), or Social Security Disability Insurance.	▪ "Long-Term Disability Plan" in the *Sick Leave & Disability* section ▪ "Medical Leave of Absence" in the *Time Off and Leaves* section ▪ You can also contact the Employment Development Department for State Disability Insurance, the Social Security Administration or the Company's Social Security Advocate for Social Security benefits, and the third-party LTD administrator for information on the Long-Term Disability Plan
What are your options regarding medical, dental, vision, and life and accident coverage? Certain coverages may be continued when you are out on LTD.	▪ *Health Care Participation* section ▪ *Medical Coverage for Participants on Long-Term Disability* section
Have you been contributing to Health Care and/or Dependent Care Flexible Spending Accounts? Your HCFSA and DCFSA contributions will stop when you go on LTD. You can submit claims for reimbursement from the HCFSA and DCFSA for eligible expenses incurred during the months in which you were an active employee, excluding time spent on an unpaid leave. Be sure to submit and substantiate your claims to the Company's third-party Claims Administrator Your Spending Account (YSA), if you're an Anthem member or if you have waived PG&E-sponsored medical coverage or with KPIC if you're a Kaiser Permanente Insurance Company member) by March 31 of the following plan year. If you are on LTD during the annual Open Enrollment period, you may not elect to contribute to the HCFSA or DCFSA.	▪ "If you go on Long-Term Disability or Workers' Compensation" in the *Flexible Spending Accounts* section

Things to Consider	See…
Do you know what will happen to your Health Account? If you have a Health Account because you are enrolled in the Health Account Plan (HAP), you will lose eligibility at the end of the month in which you go on LTD. However, you can continue to use your Health Account until it is exhausted. Be sure to submit and substantiate your claims to the Company's third-party Claims Administrator, Your Spending Account (YSA) if you're an Anthem member, or with KPIC if you're a Kaiser Permanente Insurance Company member) by March 31 of the following plan year. If you return to active status and re-enroll in the HAP within the same calendar year, your Health Account balance will be reinstated.	▪ "If You are on Long-Term Disability" in the *Health Account* section

Step Two — Take Action

After you've considered your options and what you need to do, follow these steps.

What to Do	For Information and Assistance
As soon as possible	
Notify the necessary parties when you will need to be absent from work ▪ Immediately notify the Company's Leave Administrator, who will oversee your absence and counsel you on FMLA, similar state leave laws and/or Company leave programs and will refer you to the Long-Term disability benefits administrator, as appropriate. ▪ Notify your manager or supervisor immediately regarding your absence.	▪ Contact the Company's Leave Administrator at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363. ▪ See "Medical Leave of Absence" in the *Time Off and Leaves* section. ▪ See "Long-Term Disability Plan" in the *Sick Leave & Disability* section.

You Become Terminally Ill or Die While an Active Employee

If your death occurs while you are actively employed and enrolled in a Company-sponsored medical plan, your survivors who are covered under your plan at the time of your death will be eligible to continue medical plan coverage under the Company-sponsored medical plan for surviving dependents. For more details on the medical benefits for survivors of active employees, see "Medical Benefits for Survivors of Active Employees," below. Your covered dependents will also have the option of continuing medical, dental, vision, and/or Employee Assistance Program (EAP) coverage through COBRA for a limited amount of time. See "Continuing Coverage Under COBRA" in the *Health Care Participation* section for a description of this type of continued health plan coverage.

If you have earned a vested pension benefit under the Retirement Plan, your spouse or your named beneficiary may be eligible to receive survivor benefits. For more details, see "If You Die Before You Retire" section of *Retirement – Final Pay Pension Benefit* section. In addition, your spouse or named beneficiary could be entitled to your Retirement Savings Plan account balance. See "If You Die" in the *Retirement Savings Plan* section.

Medical Benefits for Survivors of Active Employees

In the event of your death as an active employee who is covered under a Company-sponsored medical plan, your enrolled surviving spouse/registered domestic partner and/or enrolled Eligible Dependent children may continue their coverage in a Company-sponsored medical plan for surviving dependents by paying the full cost of coverage.

If you die as an active employee from injuries sustained in the course of your employment while performing your job and you are covered under a PG&E-sponsored medical plan, your enrolled surviving dependents will be eligible for PG&E-paid coverage for up to six months, subject to the eligibility rules for the Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents. After six months, the surviving dependents may continue their PG&E-sponsored medical coverage by paying the full cost of coverage. In addition, if at the time of your death you are covered under a PG&E-sponsored dental plan, vision plan or the Employee Assistance Program (EAP), your enrolled surviving dependents will be eligible to continue their coverage through PG&E-paid COBRA for up to six months. After six months and until expiration of COBRA rights, the surviving dependents may continue their PG&E-sponsored dental, vision and EAP coverage by paying the full COBRA rate. For more information on COBRA, see "Continuing Coverage Under COBRA" in the *Health Care Participation* section.

Coverage in the PG&E Health Care Plan for Retirees and Surviving Dependents will continue for your eligible surviving family members until:

- your dependents become enrolled under another group health care, hospital, surgical or medical plan;
- your dependents do not make the required monthly premium contributions;
- your spouse remarries or enters into a registered domestic partnership;
- your registered domestic partner enters into another registered domestic partnership or marries;
- your children no longer qualify as Eligible Dependents according to the plan, or
- your spouse/registered domestic partner/Eligible Dependent drops coverage.

Survivors Lose Eligibility When…

Once a surviving spouse/registered domestic partner or Eligible Dependent:

- waives coverage,
- does not make the required premium contributions, or
- loses coverage for any reason,

he or she will be ineligible to re-enroll in the plan at any time in the future.

Step One — Understand Your Options

It's important for you and your family members to know about the benefits and programs that are available, including those available to your family members in case you are diagnosed with a terminal illness or in case you or a family member dies. Make sure that your family members know whom they can contact to find out what benefits are available. Consider the following:

Things to Consider	See…
In case of your terminal illness	
Do you need to update your beneficiary designations? ▪ Review and update beneficiary designations for your Retirement Plan, Retirement Savings Plan and insurance coverages to ensure that if you die, your death benefits will go to the person(s) you want to receive them.	▪ "Beneficiary Designation" in the *Life and Accident Insurance Plans* section ▪ "If You Die Before You Retire" in the *Retirement Plan — Final Average Pay Pension Benefit* subsection and "If You Die Before You Retire" in the *Retirement Plan — Cash Balance Pension Benefit* subsection of the *Retirement Benefits* section ▪ The "Retirement Savings Plan" in the *Retirement Benefits* section

Things to Consider	See…
Should you request a Living Benefit payment from the Basic Term Life Insurance and/or Supplemental Life Insurance Plans? An early cash payment option, called the Accelerated Benefit Option (ABO), is included under the Group Life Insurance Plan. This cash payment option allows an employee who is terminally ill and whose death is expected within one year or less to receive a portion of his or her life insurance benefit. You must have at least $10,000 in life insurance coverage to qualify for this option.	▪ "Accelerated Benefit Option (ABO)" in the "How Your Benefit Is Paid" subsection of *Life and Accident Insurance Plans* section
Are you eligible to receive disability benefits from PG&E? ▪ Notify the Company's Leave or Long-Term Disability Administrator to determine whether you are eligible to receive disability benefits.	▪ Long-Term Disability Plan subsection under the *Sick Leave and Disability* section ▪ You can also contact the Employment Development Department for State Disability Insurance, the Social Security Administration or the Claims Administrator for the Long-Term Disability Plan.
If you are terminally ill, should you consider hospice care?	▪ For information on medical coverage, see the description of the Health Account Plan (HAP) in this Handbook or contact your medical plan directly (see the *Contacts section*).
If a family member dies	
Will you need to take time away from work?	▪ "Funerals" in the *Time Off and Leaves* section ▪ "Personal Leave of Absence" in the *Time Off and Leaves section*
Do you need to update your beneficiary designations? ▪ Review and update beneficiary designations for your life and accident insurance, Retirement Savings Plan and Retirement Plan to ensure that if you die, death benefits will go to the person(s) you want to receive them.	▪ "Beneficiary Designation" in the *Life and Accident Insurance Plans* section ▪ "If You Die Before You Retire" in the *Retirement Plan — Final Average Pay Pension Benefit* subsection and "If You Die Before You Retire" in the *Retirement Plan — Cash Balance Pension Benefit* subsection of the *Retirement Benefits* section ▪ The "Retirement Savings Plan" in the *Retirement Benefits* section
Should you reduce or stop your Health Care and/or Dependent Care Flexible Spending Account participation?	▪ "The Accounts Available" and "How HCRAs, LPHCRAs and DCRAs Work" in the *Flexible Spending Accounts* section ▪ "Flexible Spending Account Limitations" in the *Flexible Spending Accounts* section ▪ "Setting Up Your Flexible Spending Accounts" in the *Flexible Spending Accounts* section
If you die	
Your surviving spouse or registered domestic partner and other eligible family members may be eligible to apply for COBRA coverage (or a COBRA coverage equivalent) if their coverage would otherwise end because of your death. Your family or survivors should contact the HR Service Center.	▪ "Continuing Coverage Under COBRA" in the *Health Care Participation* section ▪ Email the HR Service Center at hrbenefitsquestions@exchange.pge.com, or contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Step Two — Take Action

These are the steps to take in case of terminal illness or death.

What to Do	For Information and Assistance
After a family member's death	
Inform the HR Service Center of the death as soon as possible	▪ Email the HR Service Center at hrbenefitsquestions@exchange.pge.com, or contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.
Family member coverage Cancel the family member's coverage under PG&E Plans (Medical, Dental and Vision) within 31 days of his or her death.	
Flexible Spending Accounts Reduce or stop your Flexible Spending Account contributions within 31 days of your family member's death (if applicable).	
Review and update your beneficiary designations as necessary ▪ Life Insurance ▪ Accidental Death and Dismemberment Insurance ▪ Business Travel Accident Insurance ▪ Retirement Savings Plan ▪ Retirement Plan	▪ "How Your Benefit Is Paid" in the *Life and Accident Insurance Plans* section ▪ "Beneficiary Designation" in the *Life and Accident Insurance Plans* section ▪ "If You Die Before You Retire" in the *Retirement Plan — Final Average Pay Pension Benefit* subsection and "If You Die Before You Retire" in the *Retirement Plan — Cash Balance Pension Benefit* subsection of the *Retirement Benefits* section ▪ The "Retirement Savings Plan" in the *Retirement Benefits* section
After your death	
Your survivors should take the following steps: ▪ Inform your manager or your immediate supervisor of your death, and the HR Service Center as soon as possible to begin receiving survivor benefits. ▪ To continue PG&E health coverage under COBRA (or a COBRA coverage equivalent), your eligible survivors should return the COBRA election notice, payment, and any supporting documentation to the COBRA Administrator within 60 days of the date on which their PG&E coverage ends or the date of the COBRA election notice, whichever is later. Qualified beneficiaries have 45 days from the date of their election to pay their initial cost of coverage. ▪ Consider consulting with a qualified tax or financial advisor before receiving payment from any life insurance and/or retirement plans.	▪ Email the HR Service Center at hrbenefitsquestions@exchange.pge.com, or contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Annual Enrollment

The following subsections describe how your benefits are affected at annual Open Enrollment and what actions you may need to take:

- When You Enroll for Benefits Each Year and
- You Need to Make a Mid-Year Change

You Enroll for Benefits Each Year

You will be given the opportunity to make certain benefit elections on an annual basis. The cost for each benefit option will be included in your Open Enrollment materials.

You may change your annual elections for medical, dental, vision, and Flexible Spending Accounts during the Open Enrollment period each fall, with your new elections taking effect on January 1 of the following year.

During Open Enrollment, you may add Eligible Dependents or delete dependents from your coverage. (Remember, Ineligible Dependents must be deleted promptly and, in any event, within 31 days of the time when they lose eligibility.) Dependents dropped during Open Enrollment may not be eligible for COBRA. Contact the HR Service Center for eligibility rules.

Open Enrollment each year is a useful reminder to make sure you're on track for your retirement savings goal. Review the Tools and Learning section on Fidelity NetBenefits (www.401k.com) or log on to Financial Engines (follow the link from Fidelity NetBenefits) to ensure your savings are adequate to meet your retirement goals. It's also a good time to review your beneficiaries for the life insurance and retirement plans.

Step One — Understand Your Options

Things to Consider	See…
▪ Have you checked with your dependents to determine their needs for the upcoming year?	
▪ Is the plan you selected last year sufficient for your needs? Will you need more coverage or less, based on life changes you anticipate?	
How much will coverage cost for the upcoming year?	▪ Your annual enrollment materials and the descriptions of costs in each of the plan description sections in this Handbook
How much will you spend in medical expenses under the Health Account Plan?	▪ Use the PG&E **Medical Expense Estimator** to estimate your costs under the Health Account Plan (HAP). You can also calculate amounts to contribute to the Health Care Flexible Spending Account (HCFSA), including your potential tax savings by contributing to the HCFSA.
What if you were previously enrolled in the Health Savings Account Medical Plan and still have money in your Health Savings Account (HSA)?	▪ You can still withdraw unused HSA balances for eligible health expenses because you own the funds in your account. For 2014 and 2015, UMB Bank will administer your HSA and PG&E will continue to pay UMB Bank account fees. Starting in 2016, you'll need to pay the account administration fees to UMB Bank. Contact UMB Bank at 1-866-520-4HSA (4472) for more information.

Step Two — Take Action

Enroll for coverage before the annual enrollment period deadline.

If You Do Not Enroll: Default Coverage

If you do not enroll or miss the deadline during the annual Open Enrollment period, you will automatically receive the following coverage:

- If you are currently enrolled in the Anthem Health Account Plan (HAP) administered by Anthem Blue Cross (for you and your enrolled dependents, as listed on your Enrollment Worksheet), you will continue to be enrolled in the Anthem HAP. If you are currently enrolled in the Health Account Plan administered by Kaiser Permanente Insurance Company (KPIC), you will continue to be enrolled in the KPIC HAP administered by Kaiser Permanente Insurance Company (for you and your enrolled dependents, as listed on your Enrollment Worksheet), if Kaiser Permanente is still available where you live for the next calendar year. If Kaiser is not available to you for the next calendar year, you will be switched to the Anthem HAP. If you are not currently enrolled in a medical plan, you will have no medical coverage.
- Your current dental coverage (for you and your enrolled dependents, as listed on your Enrollment Worksheet)
- Your current vision coverage (for you and your enrolled dependents, as listed on your Enrollment Worksheet)
- No Flexible Spending Account contributions

Once effective, your elections will remain in effect for the entire calendar year.

For information on Life and Accident insurance enrollment, see "Changing the Level of Your Coverage" in the *Life and Accident Insurance Plans* section.

You Need to Make a Mid-Year Change

You may only make changes during the calendar year if you:

- Have an eligible change-in-status event: See "Change-in-Status Events" on page 82,
- Qualify for a HIPAA Special Enrollment Period: See "HIPAA Special Enrollment Periods" in the *Health Care Participation* section; or
- Retire: See the *Health Care Participation* section and the *Retirement Benefits* section

How Long Changes Last

Any mid-year change is for the remaining months in the Plan year unless you make additional changes because you have another change-in-status event or qualify for another HIPAA Special Enrollment Period.

Other Rules

The other rules covered here include:

- Change-in-Status Events and
- The Timeline for Health and Welfare Benefit Enrollment.

Change-in-Status Events

Following is a list of some eligible change-in-status events.

- Marriage or the establishment or a registered domestic partnership (for employees and retirees only)
- Dissolution of marriage (including final divorce or annulment), legal separation, or termination of a registered domestic partnership. (Please note that you cannot enroll your ex-spouse or former registered domestic partner on your Company-sponsored health care plans even if a court orders you to provide coverage.)
- The birth or adoption of a child, or your court-ordered appointment of legal guardianship for a child.
- The placement of a child for foster care.
- The death of your spouse/registered domestic partner or dependent child.
- Your child or your registered domestic partner's child reaching the plan's age limit or entering the military.
- Your dependent child regaining eligibility.
- You or your dependent becoming Medicare- or Medicaid-eligible.
- A change in caregivers, or a change in the cost for the services of a caregiver who is not a relative (for Dependent Care Flexible Spending Account purposes only).
- A move out of your HAP claims administrator's service area (applies to change of medical plan only).
- A change in the employment of your spouse/registered domestic partner or dependent that results in a gain or loss of health care coverage.
- A change to or from full-time or part-time employment by you or your spouse/registered domestic partner or dependent, if health plan eligibility is affected.
- The retirement of your PG&E active employee spouse or registered domestic partner if you are covered as his or her dependent on a health care plan.
- An unpaid leave of absence taken by you, your spouse or registered domestic partner that significantly affects the cost of your health care coverage. (Please note that the event of beginning or returning from an unpaid leave of absence, by itself, is not a change-in-status event).
- A Management or Administrative & Technical employee on an unpaid leave of absence can cancel their benefit coverage and enroll under the coverage of his/her Management or Administrative & Technical PG&E spouse or registered domestic partner for medical, dental and/or vision.

Special Rules for Registered Domestic Partnerships

Events that relate to a registered domestic partnership, such as the establishment or dissolution of that partnership, are not change-in-status events which permit a change in your pre-tax contributions unless your registered domestic partner is your tax dependent or the children of your registered domestic partner are your tax dependents. See "Change-in-Status Events and Other Changes Involving a Registered Domestic Partnership" under "Change-in-Status Events" on page 82.

Changes Consistent with the Change-in-Status Event

If you have a change-in-status event as described in this section, you may make changes in your benefits coverage that are generally consistent with your change-in-status event. For example, if you get divorced, you must disenroll your ex-spouse; however, you may not add other dependents or change plans.

In addition, with certain status changes, you can either join a plan if you are not already in one (see "HIPAA Special Enrollment Periods" in the *Health Care Participation* section), or you can "opt out" of a plan by declining coverage (see "Declining Medical, Dental and/or Vision Coverage" under "You Join PG&E" on page 41).

Don't Miss the Deadlines!

Call the HR Service Center within 31 days of any change-in-status event (180 days for births or adoptions) that may affect your benefits. Written documentation may be requested. After 31 days 180 days for births or adoptions), you will not be able to add dependents, or change the amount you contribute to your Health Care Flexible Spending Account/Dependent Care Flexible Spending Account until the next Open Enrollment period. Provided you notify the HR Service Center within 31 days of any change-in-status event (180 days for births or adoptions), the change in coverage for all newly-enrolled dependents will take effect:

- on the date of birth of your newborn or newly-adopted child(ren); or
- on the date you assume physical custody or financial responsibility for an adopted child; or
- on the first day of the month following notification of your change-in-status event for all other status changes.

Change-in-Status Events and Other Changes Involving a Registered Domestic Partnership

You may request benefit changes if you establish a registered domestic partnership or experience a change in the status of your registered domestic partnership. However, because federal law does not generally recognize domestic partnerships, any mid-year changes you request will not be allowed to cause a change in the cost for benefits that you pay for with pre-tax contributions. For example, if you are participating in the Health Account Plan (HAP) and, as a result of establishing a registered domestic partnership, your registered domestic partner adds you to his/her medical coverage, you may not drop medical coverage mid-year for yourself because the change would reduce your pre-tax contributions. If the mid-year change(s) you request results in an increased cost, such as adding a new registered domestic partner and/or his/her dependent(s) to your medical coverage, the amount of increase must be taxed as imputed income. You may only make a mid-year change to benefits that you pay for on an after-tax basis.

The exception to this rule is if your registered domestic partner, or the child(ren) of your registered domestic partner are your tax dependents under Internal Revenue Code Section 152, as amended by Code Section 105(b). If you fall under this exception, you must fill out a "Certification of Tax Dependency" form annually to receive the increased benefit for your dependents without tax implications.

If you have a change in a registered domestic partnership, contact the HR Service Center to determine what mid-year changes, if any, you may be allowed to make and what you must do to elect a change. If your requested changes are not allowed on a mid-year basis, you will need to wait until the next Open Enrollment to make your changes.

Timeline for Health and Welfare Benefit Enrollment

The following chart lists the time frames within which you must enroll for various types of events, and the consequences of not meeting these time frames.

Type of Enrollment	Time Frame	Consequence of Not Meeting Time Frame
First-Time Enrollment Changes are effective the first day of the month following receipt of your elections, provided you complete an enrollment form within 31 days of your date of hire or transfer.		
New Hire	You may enroll yourself and Eligible Dependents within 31 days of hire.	You will receive Default Coverage (see "Default Coverage" under "You Join PG&E" on page 41).
Transfer from Management or Administrative & Technical position	You may enroll yourself and Eligible Dependents within 31 days of transfer.	You will receive limited coverage, as described under "You Transfer from a Management or Administrative & Technical Position" on page 45.
Change-in-Status Events Changes are effective the first day of the month following timely notification. (See "Change-in-Status Events" on page 82 for additional information.) NOTE: Changes in the status (other than termination) of a registered domestic partnership and changes concerning children of a registered domestic partnership do not qualify as a change-in-status event unless the affected individual is your tax dependent. See "Change-in-Status Events and Other Changes Involving a Registered Domestic Partnership" under "Change-in-Status Events" on page 82.		
Marriage or Establishment of a Registered Domestic Partnership	You may add yourself and/or Eligible Dependents within 31 days of marriage or establishment of a registered domestic partnership.	You will not be able to enroll in or add Eligible Dependents to the medical, dental, or vision plans until the next Open Enrollment period, unless you have another eligible change-in-status event or qualify for a HIPAA special enrollment period, and the change is consistent with the event.
Divorce or Legal Separation (must be final), Annulment or Termination of a Registered Domestic Partnership	You must drop your ex-spouse, registered domestic partner, step-children, and any other former dependents within 31 days of final decree or termination of a registered domestic partnership. You may also drop other dependents.	If you cover Ineligible Dependents, you will be required to pay the Company an amount equal to the cost of coverage for the period of time during which an Ineligible Dependent is enrolled, up to a maximum of two years of coverage costs. Please note that knowingly covering an ineligible dependent is considered fraud, and can be grounds for termination of employment.

Type of Enrollment	Time Frame	Consequence of Not Meeting Time Frame
Birth or Adoption of Child	You may add yourself, your spouse, the newborn or adopted child, and other Eligible Dependents within 180 days of birth or adoption (assumption of physical custody or financial responsibility). You must notify the HR Service Center, not your medical plan, of any change-in-status events.	On the 180th day, if you do not enroll your newborn or newly-adopted child, the health coverage provided by the health plans will terminate retroactively to the date of the child's birth or adoption. No health expenses for the child will be covered by the Plan. You will not be able to enroll in or add Eligible Dependents to the medical, dental or vision plans until the next Open Enrollment period, unless you have another eligible change-in-status event or qualify for a HIPAA special enrollment period, and the change is consistent with the event. However, in some cases, a newborn/adopted child can be covered for a limited period of time, according to plan provisions. No Medical Plan — You will not be able to enroll in or add Eligible Dependents to the medical, dental or vision plans until the next Open Enrollment period, unless you have another eligible change-in-status event or qualify for a HIPAA special enrollment period, and the change is consistent with the event.
Employee's Court Appointment of Legal Guardianship or Becoming a Foster Parent	You may add your legal ward or foster child within 31 days of appointment of legal guardianship or placement for foster care.	You will not be able to enroll Eligible Dependents in the medical, dental or vision plans until the next Open Enrollment period, unless you have a change-in-status event and the change is consistent with the event.
Dropping Enrollment Due to Death of Dependent	You must drop enrollment of your deceased dependent within 31 days of your dependent's death.	If you cover Ineligible Dependents, you will be required to pay the Company an amount equal to the cost of coverage for the period of time during which the Ineligible Dependent is enrolled, up to a maximum of two years of coverage costs.
Dropping Enrollment Due to Dependent's Loss of Eligibility	You must drop enrollment of an Ineligible Dependent within 31 days of the dependent's loss of eligibility.	If you cover Ineligible Dependents, you will be required to pay the Company an amount equal to the cost of coverage for the period of time during which the Ineligible Dependent is enrolled, up to a maximum of two years of coverage costs.
Dependent Regains Eligibility	You may add a dependent within 31 days of the date on which the dependent regains eligibility.	You will not be able to enroll in or add Eligible Dependents to the medical, dental or vision plans until the next Open Enrollment period, unless you have another eligible change-in-status event and the change is consistent with the event.

Type of Enrollment	Time Frame	Consequence of Not Meeting Time Frame
Start or End of Spouse's/Registered Domestic Partner's Employment	You may add or drop your spouse/registered domestic partner within 31 days of the start/end of spouse's/registered domestic partner's employment.	You will not be able to add or drop your spouse/registered domestic partner until the next annual Open Enrollment period, unless you have another change-in-status event or qualify for a HIPAA special enrollment period and the change is consistent with the event.
You or Your Spouse/Registered Domestic Partner Changes from Full-Time to Part-Time Employment or Vice Versa	You may add or drop your spouse/registered domestic partner and other Eligible Dependents within 31 days of the change.	You will not be able to add or drop your spouse/registered domestic partner until the next annual Open Enrollment period, unless you have another change-in-status event or qualify for a HIPAA special enrollment period and the change is consistent with the event.
Spouse/Registered Domestic Partner Has Significant Change of Health Coverage at Place of Employment	You may add or drop yourself, your spouse/registered domestic partner, and other dependents as consistent with the change within 31 days of change.	You will not be able to add or drop yourself, your spouse/registered domestic partner, and/or other dependents until the next annual Open Enrollment period, unless you have another change-in-status event or qualify for a HIPAA special enrollment period and the change is consistent with the event.
Annual Open Enrollment		
Annual Open Enrollment (for following calendar year)	You may add or drop yourself and Eligible Dependents within the designated Open Enrollment period.	Your current elections (if the plans are available) and dependent coverage will continue into the following year, with the exception of the Health Care Flexible Spending Account, and the Dependent Care Flexible Spending Account, if applicable. If you want to contribute to the Flexible Spending Accounts, you must actively enroll during Open Enrollment.
Retirement		
Your Retirement	You may add yourself or your Eligible Dependents (if not currently enrolled) at the time of your retirement. You may also change medical plans.	You will not be able to enroll yourself or Eligible Dependents in a retiree medical plan until the next Open Enrollment period. If you decline medical coverage and want to subsequently enroll, you must notify the HR Service Center by September 1 of any year in order to receive an Open Enrollment package for the following plan year. As a retiree, you may only make changes on a mid-year basis if you are already enrolled in a medical plan and have a change-in-status event that allows for a change.

Health Care Benefits

This section describes the available medical (including mental health and substance abuse and prescription drugs), dental and vision coverage provided pursuant to the Pacific Gas and Electric Company Health Care Plan for Active Employees (as used in this section, "the Plan.")

This section is organized into subsections and chapters, to help you find the information you want. These are:

- **Health Care Participation,**
- **Health Account Plan (HAP),**
- **Wellness Program,**
- **Employee Assistance Program,**
- **Medical Coverage for Participants on Long-Term Disability,**
- **Health Account,**
- **Mental Health and Substance Abuse,**
- **Prescription Drugs,**
- **Dental coverage, and**
- **Vision coverage.**

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation. The plans and benefits described in this section are also applicable to employees of designated subsidiaries and affiliates, but only to the extent that such entities are participating employers with respect to the described plans or programs and such employees meet the eligibility requirements of the plans or programs.

Additional Information

In addition to the information in this section, there is also important information about your benefits in other parts of this Handbook. Be sure to review the *About this Handbook* section, the *Benefits at a Glance* section, the *What If...* section, and the *Rules, Regulations & Administrative Information* section.

Responsibility for Your Health Care

While the Company has contracted with reputable health care plan administrators to provide health care services, neither the Company or any participating employer nor the Plan can ensure the quality of care you receive. The health care vendors contract with the providers in their networks; the Company does not contract with any of the network doctors, hospitals or other providers directly.

Health plan participants always have a choice in the services they receive and who provides those services, regardless of what the health care plan administrator covers or pays.

Plan Documents and Administration

The plan document for The Pacific Gas and Electric Health Care Plan for Active Employees (the "Health Care Plan") incorporates the terms of this Summary of Benefits Handbook which pertain to the Health Care Plan, the documents that are Summaries of Material Modifications to the Health Care Plan, which may include Open Enrollment guides, and the Employee Assistance Program Evidences of Coverage. If a conflict exists between these Health Care Plan documents and any other communications or documents, the terms of these Health Care Plan documents shall govern the operation of the Health Care Plan.

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

Health Care Participation

You are eligible to enroll for health care coverage if you are a full-time or part-time employee represented by the IBEW, ESC, or SEIU, regardless of whether you are a probationary employee or have reached regular status. Participation begins on the first day of the month following receipt of your elections, provided you complete and return an enrollment form to the HR Service Center within 31 days of your date of hire or transfer into a union-represented position. For example, if you were hired on February 1 as a union-represented employee, and you return a completed form on February 15, your elections would be effective on March 1.

New hires who do not enroll within 31 days will be required to wait until the next Open Enrollment period to enroll, with coverage effective January 1 of the following year, unless you have an eligible change-in-status event before then.

You are not eligible to enroll for active employee health care coverage if you are a contractor, agency, or hiring hall employee or a retiree of the Company (unless you are a retiree who has been rehired as a regular employee). Intermittent employees and other temporary employees who are not expected to become regular employees are also not eligible for coverage.

In This Section — See Page

Eligible Dependents

You may also enroll your Eligible Dependents in the health care plans.

Please note that federal law (Medicare Secondary Payer Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (42.U.S.C.1395y(b)(7)&(b)(8)) requires the Company to have Social Security numbers (SSNs) on file for many individuals enrolled in a PG&E-sponsored medical plan. This includes, among others, individuals aged 45 or older as well as certain categories of individuals younger than age 45. By enrolling your Eligible Dependents in PG&E-sponsored health care plans, you agree to provide their SSNs. If you fail to do so, your enrolled dependent(s) may be terminated from medical coverage. If your dependent's correct SSN is missing, please contact the HR Service Center at 415-973-4357 or 800-788-2363, and provide the SSN in order to continue medical coverage for that dependent.

Eligible Dependents include:

- Your legally married spouse, legally state-recognized common-law spouse, or registered domestic partner;
- Your children who are under age 26, including stepchildren, children born during a registered domestic partnership, foster children, legally adopted children, and children for whom you have been permanently appointed legal guardianship by a court (does not include the legal wards of your spouse);
- The children of your spouse or registered domestic partner who are under age 26, including legally adopted children. Note that a child for whom your spouse or registered domestic partner is the legal guardian is not an eligible dependent;
- Your disabled children or those of your spouse/registered domestic partner who are age 26 or older, who are certified as disabled by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), and who have been approved by a PG&E-sponsored medical plan provider for continued coverage before they reach age 26. For more information, please contact the Member Services department of the medical plan in which you are enrolled (also see "Disabled Dependents," under "Eligible Dependents" for more information); or
- Your family member or registered domestic partner if you both are union-represented employees or you both are retirees. You each have the option of electing coverage as an "employee" or "retiree," or you can be covered as a "dependent" of the other. However, you may not be covered as both. In addition, you may not be covered as both an employee and a retiree. Management and Administrative & Technical employees may not cover union-represented employees and visa-versa.

Employee/Retiree Couples

If you and your family member or registered domestic partner are both union-represented employees or are retirees, you each have the option of being covered as an "employee" or "retiree," or you can be covered as a "dependent" of the other. However, you may not be covered as both. In addition, you may not be covered as both an employee and a retiree.

Qualified Medical Child Support Orders

Federal law requires employer-sponsored group health plans to recognize Qualified Medical Child Support Orders (QMCSOs) by providing benefits for eligible children of plan participants in accordance with the terms of the orders. A court order or a National Medical Support Notice issued by a State child support enforcement agency must identify the child who is the "alternate recipient" of health care coverage, describe the type and duration of coverage, and cannot require a health plan to provide benefits which are not otherwise available under the plan. The Company will determine if a court order or a National Medical Support Notice satisfies the legal requirements to be a QMCSO in accordance with the written procedures established under the Plan. You may request a copy of the procedures, free of charge, by contacting the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

- You will be notified of the receipt of an order affecting your children and the Company's procedures and determination with respect to the order. If an order satisfies the legal requirements, coverage may be provided for your child until the earlier of:
- The date the coverage stops as provided in the order;
- Your termination of coverage as an employee (subject to your right to elect continuation of coverage); or
- The date the child ceases to be an Eligible Dependent.

The Company will enroll the child pursuant to the court order and deduct any required contributions, even without the participant's direct consent. If you are not already enrolled, you must elect to participate at the time you are required to provide coverage for your child(ren); you may not enroll your child(ren) unless you also elect coverage for yourself. If you are enrolled in a health care program that will not cover dependent children who do not reside with you, you may change to a program for which you are eligible that will cover your children. If you do not voluntarily change, the Company will enroll you in the Health Account Plan (HAP) administered by Anthem Blue Cross and will deduct the required monthly contributions associated with the coverage under the HAP.

If a Participating Employer receives a court-ordered judgment or decree requiring you to cover an eligible dependent child, the child will be enrolled in your health care plans, pursuant to the court order or judgment. Coverage for the child will be effective the first of the month following enrollment by PG&E, and your health plan contributions will be adjusted to reflect the coverage of the child, if applicable.

Registered Domestic Partners

Registered domestic partners of employees are eligible for coverage under the Company's medical, dental and vision care plans.

To be eligible for domestic partner benefits, the domestic partnership must be registered with a government entity (e.g., the City and County of San Francisco), pursuant to state or local law authorizing such registration. For a partial list of municipalities that currently offer a domestic partner registry, you can access an online copy of "Your Guide to Domestic Partner Benefits at Pacific Gas & Electric Company" under the "Domestic Partner Benefits Guide" link on the **Benefit Plan Documents** section of the PG&E@Work intranet, or you can request a copy by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

If you wish to cover your registered domestic partner under any Company-sponsored benefit plans, you must contact the HR Service Center within 31 days of your domestic partnership registration date.

If you fail to do so, you must wait until the next Open Enrollment period to enroll your registered domestic partner. You may be required to provide proof of domestic partnership registration to the Company upon request.

Tax Implications of Coverage for Your Registered Domestic Partner or Children of Your Registered Domestic Partner

Federal Taxes

It is important to note that the value of the health care coverage provided for a registered domestic partner or any enrolled dependent children of a registered domestic partner is treated as income to you for federal tax purposes. PG&E will report the value of the coverage as income on your Form W-2 and will withhold federal income and employment taxes. The amounts taxable to you can be substantial. For exact calculations of the current year's imputed income for your specific plan and coverage level, please refer to the appendix of the "Your Guide to Domestic Partner Benefits at Pacific Gas & Electric Company" under the "Domestic Partner Benefits Guide" link in the **Benefit Plan Documents** section of the PG&E@Work intranet.

An exception to these income reporting and withholding rules applies if your registered domestic partner or children of your registered domestic partner are your tax dependents under Internal Revenue Code section 152, as amended by Code section 105(b).

Note: Many registered domestic partners do not qualify as tax dependents. However, if your enrolled, registered domestic partner, or his or her enrolled children are your tax dependents and you complete a Certification of Tax Dependency form, the value of the health care benefits will not be reported as taxable income. You must complete a new certification each year. If you don't receive a Certification of Tax Dependency form for the upcoming tax year, please call the HR Service Center to request a form. Forms received after the last day of the year will not be processed until the first of the following month after receipt.

You are encouraged to consult a tax professional before claiming that your registered domestic partner and/or the children of your registered domestic partner qualify as your tax dependents.

California Taxes

For California income tax purposes, the value of the health care benefits provided to your registered domestic partner and/or your registered domestic partner's dependents may be excluded from your taxable income if your partnership is registered with California's Secretary of State and if certain other conditions are met (i.e., you must be in a same-sex partnership or one or both partners in an opposite-sex partnership must be over the age of 62). Please contact your tax advisor and the HR Service Center for more information.

If you reside in a state other than California that recognizes domestic partners, you must satisfy that state's registration requirements. Exemption of state income tax on the imputed income will be based on that state's tax code.

More Eligibility and Tax Information for Registered Domestic Partners

Employees can find out more about eligibility and general information regarding taxation for registered domestic partner benefits by accessing an online copy of "Your Guide to Domestic Partner Benefits at Pacific Gas & Electric Company" under the "Domestic Partner Benefits Guide" link in the **Benefit Plan Documents** section of the PG&E@Work intranet, or you can request a copy by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363. However, employees are encouraged to seek advice from a tax professional for any questions they may have.

Also see "Change-in-Status Events and Other Changes Involving a Registered Domestic Partnership" under "Change-in-Status Events" in the *What If…*section.

Registered Domestic Partner Dependents

The State of California considers a child born or adopted during the course of a registered domestic partnership to be a natural-born child to both partners — regardless of who is the child's biological birth-parent — and, consequently, such a child will continue to be considered an eligible dependent for purposes of health plan coverage in the event the registered domestic partnership is terminated. However, should your registered domestic partnership legally come to an end, any child born to or adopted by your registered domestic partner prior to the establishment of your registered domestic partner union must be dropped from your PG&E-sponsored health plans within 31 days, unless you have adopted the child or you have legal guardianship of the child.

Disabled Dependents

You can arrange for coverage to continue past the customary age limits for an unmarried child who is incapable of self-support because of a physical or mental disability, as certified by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), provided the child's disability began and was certified through the PG&E Disabled Dependent process before he or she became otherwise ineligible for coverage. Your child must depend chiefly on you for support in order to qualify for the continued coverage and must also meet the definition of an Eligible Dependent.

For eligible dependents who are disabled and currently enrolled in a PG&E-sponsored health plan, you must contact the medical plan vendor directly to process the required certification before your disabled dependent loses eligibility. Loss of eligibility typically occurs at age 26. If you do not complete the certification on time, your disabled dependent can no longer be enrolled in the plan, effective the first of the month in which he or she is no longer eligible.

You must apply for continued coverage under a PG&E-sponsored medical plan for a disabled dependent within 31 days of the date on which your child's coverage would ordinarily end. Written proof of your child's continuing dependency must be provided upon request, but not more frequently than once a year after the two-year period following the child's attainment of the limiting age.

For more information about whether or not a dependent is eligible for coverage, please contact your benefit plan vendor. Contact information for each benefit plan vendor is listed under the *Rules, Regulations and Administrative Information* and *Contacts* sections of this Handbook.

Ineligible Dependents

Ineligible Dependents include, but are not limited to:

- A divorced, legally separated, or non-legally state recognized common-law spouse, even if a court orders you to provide health care coverage;
- A former domestic partner, or a domestic partner if your domestic partnership has not been formally registered with a valid registry;
- Parents, step-parents, parents-in-law, grandparents and step-grandparents;
- Former step-children or the step-children of a former registered domestic partner, unless they were born or adopted during the course of the registered domestic partnership or you have been appointed permanent legal guardian for them by a court;
- Children age 26 and older, unless they have been approved for continued coverage under the Disabled Dependent provision for PG&E-sponsored medical plans prior to otherwise becoming ineligible for coverage;
- Children who have entered the military (regardless of age or disability status);
- A spouse, common-law spouse, or domestic partner of your eligible child;
- Children covered as dependents under the plan of another employee or retiree of a Participating Employer;
- Grandchildren, nieces, nephews or other family members, unless you have legally adopted them or have been appointed permanent legal guardian for them by a court;
- A family member who is a union-represented employee if you are a Management or Administrative & Technical employee of a Participating Employer, or a family member who is a Management or Administrative & Technical employee if you are a union-represented employee of a Participating Employer.

Penalties for Covering Ineligible Dependents

It is your responsibility to ensure that your enrolled dependents are eligible. If you cover Ineligible Dependents, you will be required to pay the Company an amount equal to the cost of coverage for the period of time during which an Ineligible Dependent is enrolled, up to a maximum of two years of coverage. Covering an ineligible dependent is considered fraud and may be subject to termination of employment.

To drop Ineligible Dependents, contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Dependents of Employee/Retiree Couples

If both you and your spouse or registered domestic partner are an employee or retiree of the Company or PG&E Corporation, only one of you may enroll each child as an eligible family member under any one benefit plan.

If a dependent loses eligibility, you must drop the dependent from your Company health care plans within 31 days of the dependent's loss of eligibility.

If you have any questions about whether or not a dependent is eligible for coverage, you can send an email to the HR Service Center at hrbenefitsquestions@exchange.pge.com, or you can contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

If Eligibility Is Denied

To participate in a benefit plan, you and your dependents must meet the eligibility requirements and enroll or change your enrollment in the time frames specified by the plan. Before filing an eligibility appeal, you may call the HR Service Center first to see if the eligibility issue can be resolved informally.

If you are not satisfied with the outcome of your contact with the HR Service Center, you may file an eligibility appeal with the Plan Administrator by writing to:

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

If the Benefits Department denies your appeal, you will receive written notice of the denial within 60 days of receipt of the initial appeal unless, due to special circumstances, an additional 60 days is required. Such notification will set forth:

- the specific reason(s) for the denial of the appeal;
- 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 appeal and an explanation of why such material or information is necessary; and
- a description of the Plan's review procedures and the time limits applicable to such procedures.

Eligibility Appeals

If you are not satisfied with the Benefit Department's decision on your appeal, 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 decision maker in the appeals process, stating the reasons for your appeal and enclosing all documentation and any additional information to support your appeal.

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 appeal. You may also request, free of charge, access to, or copies of, all documents, records, and other information relevant to your appeal for benefits. The review will take into account all comments, documents, records, and other information submitted by you relating to your appeal, without regard to whether such information was submitted or considered at the initial benefit determination.

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 the EBAC within 60 days of the EBAC's receipt of your appeal unless, due to special circumstances, the EBAC requires additional time to respond, up to another 60 days.

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

- the specific reason(s) for the denial of the appeal;
- a 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 appeal for benefits.

Cost of Coverage

All union-represented employees who elect medical coverage make contributions toward the cost of coverage. Part-time union-represented employees also make contributions for dental and vision coverage. Employee contributions vary based on your status as an employee (full-time, part-time, on leave of absence, etc.) and the health plan and the level of coverage selected (for instance, Self Only, Self and Spouse, etc.) Employee contributions which are deducted from your paychecks generally are made on a pre-tax basis.

Contributions for Full-Time Employees

Full-time union-represented employees pay 7.5% of the actual premium for the medical plan they select. Your contributions for the medical plan you choose (if any) will be deducted from your second paycheck of each month on a pre-tax basis. Full-time employees are not required to contribute toward the cost of their dental and vision premiums.

Contributions for Part-Time Employees

If you are a regular-status employee who became a part-time employee prior to January 1, 1991, you will pay 7.5% of the cost of coverage. If you became part-time January 1, 1991, or later, you will pay 7.5% of the cost of coverage in addition to your part-time medical plan contributions, as explained in this section. Salary deductions are generally on a pre-tax basis.

The Company bases its prorated medical plan contributions for part-time employees on the cost of coverage for the Anthem Blue Cross HAP plan, regardless of what plan the part-time employee enrolls in. Part-time employees pay the difference between the Company's pro-rated contribution and the full cost of coverage for the medical plan they actually select — plus 7.5% of the cost of coverage for their selected medical plan.

The amount the Company contributes is based on the ratio of actual straight-time hours worked for the 12-month period (from October 1 of the previous year to September 30 of the current year) to the full-time hourly equivalent of 2080 hours. The Company will contribute an amount equal to this percentage multiplied by the cost of the Anthem Blue Cross HAP plan. The cost of coverage for part-time new hires will be based on an assumed schedule of 36 hours of work for their first six months of employment. When the part-time employee completes six months of service, the cost of coverage will be recalculated, based on the actual number of straight-time hours worked from their date of hire.

For regular-status employees who became part-time employees prior to January 1, 1991, no contribution is required for dental or vision coverage. For regular-status employees who became part-time employees January 1, 1991, or later, dental and vision contributions are required. The amount the Company contributes is based on the ratio of actual straight-time hours worked for the 12-month period (from October 1 of the previous year to September 30 of the current year) to the full-time hourly equivalent of 2080 hours. The Company will contribute an amount equal to this percentage, multiplied by the cost of the coverage for the dental and vision plans. The cost of coverage for part-time new hires will be based on an assumed schedule of 36 hours of work for their first six months of employment. When the part-time employee completes six months of service, the cost of coverage will be recalculated, based on the actual number of straight-time hours worked from their date of hire.

Part-time employees should review their enrollment worksheet or contact the HR Service Center if they wish to obtain their cost-sharing amounts.

Contributions for Employees on Leaves of Absence

Employees on leave of absence are also required to pay medical plan contributions. Contributions will be 7.5% or 100% of the medical plan premium, depending on the type of leave you are on. Your leave of absence package will explain your payment options while on leave.

For more information on health care coverage during a leave of absence, please see "I Take an Unpaid Leave of Absence" in the *What If...* section.

Contributions for Employees on Long-Term Disability

Employees on Long-Term Disability (LTD) will be required to pay 7.5% of their monthly cost of medical coverage. Medical contribution deductions will be taken on a pre-tax basis from the employee's Long-Term Disability check, provided the employee is receiving LTD payments.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office. Call 877-KIDS NOW or log on to www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as being eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance with paying your employer health plan premiums. The following list of States is current as of July 31, 2013. You should contact your State for further information on eligibility.

California is not participating in CHIP for 2014.

The following is a partial list of participating states.

- **ARIZONA** — CHIP

  Website: www.azahccs.gov/applicants
  Phone (Outside of Maricopa County): 877-764-5437
  Phone (Maricopa County): 602-417-5437

- **NEVADA** — Medicaid

  Website: http://dwss.nv.gov/
  Phone: 800-992-0900

- **OREGON** — Medicaid and CHIP

  Website: www.oregonhealthykids.gov

  www.hijossaludablesoregon.gov
  Phone: 877-314-5678

- **TEXAS** — Medicaid

  Website: www.gethipptexas.com/
  Phone: 800-440-0493

- **VIRGINIA** — Medicaid and CHIP

  Medicaid Website: www.dmas.virginia.gov/rcp-HIPP.htm
  Medicaid Phone: 800-432-5924

  CHIP Website: www.famis.org/
  CHIP Phone: 866-873-2647

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
866-444-EBSA (3272)

Or

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877-267-2323, Ext. 61565

Enrollment

For an overview of your enrollment options, see "Enrollment Options at a Glance" in the *Benefits at a Glance* section.

New Hire Enrollment

A New Hire Benefits Packet will be sent to your home address or delivered to you within 10 days of your date of hire. Review the options available to you and make your selections. Complete the enrollment form included in your benefit enrollment kit and return it to the HR Service Center at the address indicated on the form. You'll receive a confirmation statement within ten days of the date on which your form has been received. If you have any questions about enrolling in benefits, call the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

31-Day Deadline!

You must either fax or mail the completed enrollment form to the HR Service Center within 31 days of your hire date to avoid being placed in the limited Default Coverage described in this section.

Your medical, dental and vision benefits will go into effect on the first day of the month following the Company's receipt of your request to enroll, provided your request is received within 31 days of your hire date. For example, if you were hired February 1, and the Company received your request to enroll on February 15, your coverage will be effective on March 1.

Default Coverage

If you do not enroll within the time requirements, you will be automatically assigned the following default coverage:

- No Medical Plan Coverage (including no Mental Health and Substance Abuse coverage or Prescription Drug coverage)
- No Dental Coverage
- No Vision Coverage
- No Flexible Spending Account Contributions
- Employee Assistance Plan

Once effective, your health plan Default Coverage will remain in effect for the entire calendar year. You may not make changes to your health plan coverage until the next Open Enrollment period, unless you have an eligible change in status or qualify for a HIPAA special enrollment period, as described under "You Need to Make a Mid-Year Change" and "Change-in-Status Events" in the What If...section.

Annual Open Enrollment

Each year, you have an opportunity to change your health care coverage elections for the coming calendar year, during the Open Enrollment period. The Open Enrollment period typically occurs in the fall.

The elections you make during annual enrollment take effect on January 1 of the next year, and remain in effect for the entire year. You may not make changes to your coverage until the next Open Enrollment period, unless you have an eligible change in status or qualify for a HIPAA special enrollment period, as described under "You Need to Make a Mid-Year Change" and "Change-in-Status Events" in the What If...section.

Declining Medical, Dental and/or Vision Coverage

If you are covered under another medical plan, dental plan, and/or vision plan outside of the Company (for example, through a spouse's employer), you may want to evaluate whether or not you need medical, dental and/or vision coverage through PG&E.

Employees eligible for PG&E's health care plans can elect to decline medical coverage, dental coverage, and/or vision coverage by selecting the "opt out" elections: NO MEDICAL PLAN (including no Mental Health and Substance Abuse or Prescription Drug coverage), NO DENTAL PLAN and/or NO VISION PLAN.

About Declining Coverage

If you decline medical, dental and/or vision coverage, here is some important information you need to know:

- **If you and your family member or registered domestic partner are both union-represented employees or are retirees**, you each have the option of being covered as an "employee" or "retiree," or you can be covered as a "dependent" of the other. However, you may not be covered as both. In addition, union-represented employees cannot cover a family member or a registered domestic partner who is a Management and Administrative & Technical employee.
- You will not be able to re-enroll in a Company-sponsored medical, dental and/or vision plan until the next Open Enrollment period, unless you have an eligible change-in-status event or qualify for a HIPAA special enrollment period.
- Declining or waiving coverage does not entitle you to receive additional compensation in lieu of Company contributions.

If you have any questions about declining medical, dental and/or vision coverage, you can send an email to the HR Service Center at hrbenefitsquestions@exchange.pge.com, or you can contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Changing Your Coverage

In general, you may not change your health care benefits except during the annual Open Enrollment period. However, you may be able to change your coverage if you:

- Declined coverage because you had other coverage available, and you then lose that other coverage, or
- Experience a qualifying change-in-status event, such as getting married or divorced, having or adopting a child, or moving to an area where your chosen plan is not available.

Because change-in-status events affect more benefits than just your health care benefits, they are described under "Change-in-Status Events" in the *What If...* section.

If you declined coverage and lose your other coverage, the rules that may allow you to enroll are described under "HIPAA Special Enrollment Periods" on page 99.

HIPAA Special Enrollment Periods

A HIPAA Special Enrollment Period may be available to you and your Eligible Dependents if any of the following occur:

- 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 the employer stops contributing towards the cost of 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
- 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 losing coverage or employer contributions toward coverage; within 31 days of the date of your marriage or domestic partnership registration; within 180 days of the birth, adoption or placement for adoption of a child; or 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 due to:
  - legal separation (but only if it causes a loss of coverage);
  - divorce, death, termination of employment or reduction in hours;
  - a dependent no longer meeting eligibility requirements due to age or for other reasons;
  - you or your Eligible Dependent children no longer being covered by a health plan through your spouse's employer because you no longer reside, live, or work in the health plan's service area and have no other available health plan option; or
  - a plan no longer offering benefits to similarly-situated individuals;
- Termination of employer contributions under the other health care plan;
- The other health care coverage being through COBRA and you have exhausted COBRA coverage rights; or
- Your meeting or exceeding a lifetime limit on all benefits under another health plan.

If you are eligible for a HIPAA Special Enrollment Period due to loss of other coverage, you are eligible to elect coverage for yourself and/or your Eligible Dependent(s) in a medical plan, the Dental Plan, and/or the Vision Plan within 31 days of 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 request. 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 if you wish to enroll.

Newborn and Adoption Provision

If you are eligible for a HIPAA Special Enrollment Period due to the birth, adoption or placement for adoption of a child, you are eligible to elect coverage for yourself and/or your Eligible Dependents in a medical plan, the Dental Plan, and/or the Vision Plan within 180 days of the date of the child's birth, adoption or placement for adoption. Coverage resulting from this HIPAA Special Enrollment period will be effective retroactive to the date of birth, adoption or placement for adoption. If you do not enroll within the 180-day enrollment period, you and/or the Eligible Dependents that you did not enroll will not be covered under the Company medical, dental or vision plans, and you must wait until the next Open Enrollment period if you wish to enroll yourself and/or Eligible Dependents.

Marriage/Registered Domestic Partnership Provision

If you are eligible for a HIPAA Special Enrollment Period due to marriage or establishment of a registered domestic partnership, you are eligible to elect coverage for yourself and your Eligible Dependents in a medical plan, the Dental Plan, and/or the Vision Plan within 31 days of the date of your marriage or establishment of the registered domestic partnership. Coverage resulting from this HIPAA Special Enrollment event will be effective as of the first day of the month following receipt of your enrollment, provided you enroll within 31 days of the event. If you do not enroll within the 31-day enrollment period, you and/or the Eligible Dependents that you did not enroll will not be covered under the Company medical, dental and/or vision plans, and you must wait until the next Open Enrollment period if you wish to enroll yourself and/or any Eligible Dependents.

If You Have Other Coverage

If you and your spouse/registered domestic partner both work, it's possible that your family is covered by more than one health care plan. The process of integrating benefits among two or more plans is called coordination of benefits.

If you are enrolled in the Anthem Health Account Plan (Anthem HAP), Anthem Blue Cross will coordinate benefits with any other group health plans for which you are eligible. This means the Anthem HAP will pay benefits on a secondary basis if any of your enrolled dependents have primary medical coverage elsewhere. Be sure to contact Anthem Blue Cross to determine if and when it will coordinate benefits on a secondary basis.

The PG&E Kaiser Permanente HAP (KPIC HAP) does not coordinate with any other Kaiser Permanente plan. If you or your dependents have coverage under the PG&E KPIC HAP and you also have coverage under another Kaiser Permanente plan through your spouse or parents, no additional benefits will be paid once Kaiser has paid benefits under the plan that is primary. There is no advantage to having dual coverage with Kaiser if you are enrolled in the PG&E KPIC HAP. In addition, if you have double coverage with a non-Kaiser plan, your PG&E KPIC HAP will not pay benefits on a secondary basis if you use non-Kaiser network providers. (There are limited exceptions in which Kaiser may coordinate benefits with another non-Kaiser plan — for example, when Kaiser refers you to a non-network provider for specialized treatment which cannot be provided by Kaiser providers. Contact Kaiser Permanente for more information.)

For most plans that coordinate benefits, with the exception of the HAP's mental health and substance abuse benefits provided by ValueOptions, combined payments under all plans will be provided up to, but not more than, 100% of allowed charges. For the HAP's mental health and substance abuse benefits provided by ValueOptions, combined payments under all plans will be provided up to, but not more than, the benefits you would receive from ValueOptions alone.

If you are eligible for health care benefits under more than one plan, you should file claims under all the plans for which you qualify.

Here's how coordination of benefits works:

- One plan will pay benefits first. This is called the primary plan.
- Then, the other plans for which you qualify — the secondary plans — will pay benefits toward covered expenses left over, if any, after the primary plan pays.
- You will never be reimbursed for more than 100% of allowed charges for your covered expenses.

Claims should be filed with the primary plan first, then with any secondary plans.

In order to coordinate benefit claim payments, the HAP Claims Administrator needs to obtain certain information either from you or other covered dependents or from other health plan insurers or claims administrators. The Claims Administrator will also need to provide the other health plan insurers or claims administrators with information about you and your dependents' benefit claims. By participating in a Company-sponsored plan, you and your dependents are consenting to cooperate in providing necessary information to the health plan insurers and claims administrators and are consenting to having necessary information released so that all involved claims administrators or health plan insurers can properly coordinate benefits. The claims administrators and health plan insurers coordinate benefits according to the National Association of Insurance Commissioners' (NAIC) guidelines.

Which Plan Is Primary for You?

Here are some guidelines to help you determine which plan is primary:

- A plan that covers you as an employee will pay before a plan that covers you as a dependent.
- A plan that covers you as an active employee (or as that employee's dependent) will pay before a plan that covers you as a retired or laid-off employee or under continuation coverage.
- A plan without a coordination of benefits provision will pay benefits before a plan with such a provision.

If none of these rules applies, the plan that has covered you the longest will pay benefits first.

Which Plan Is Primary for Your Children?

Here are some guidelines to help you determine which plan is primary for your children:

- A plan without a coordination of benefits provision will pay benefits before a plan with such a provision.
- Where each plan has coordination of benefits, the following rules apply:
  - **For Married Parents or Registered Domestic Partners:** In general, the primary plan for your children is determined using the "birthday rule." This means the plan covering the parent whose birthday occurs first in the year is primary and will pay benefits first. For example, if your birthday is on January 15th and your spouse's/registered domestic partner's birthday is on June 10th, your plan pays benefits for your children first.
  - **For Separated or Divorced Parents:** Follow the rules outlined here, unless the court has specified which parent is responsible for coverage. If a child's parents are divorced or legally separated, claims should be submitted first to the plan of the parent who has custody, provided the dependent is eligible under that plan. If that parent has remarried, claims should be submitted next to the plan covering the stepparent — the spouse of the parent with custody — provided the dependent is eligible under the plan. Claims should be submitted last to the plan covering the parent without custody, provided the dependent is eligible under that plan.

  If none of these rules applies, in most cases the plan that has covered your dependent(s) the longest will pay benefits first.

Coordination with Medicare

Medicare Part A and B

For most individuals, Medicare Part A, B and D benefits currently become available at the beginning of the month in which a person reaches age 65, whether or not he or she is retired. Medicare Part A, B and D benefits usually become available to individuals before age 65 if the individual has received Social Security disability benefits for two years, or if the individual has chronic kidney disease.

If you or one of your covered dependents becomes entitled to Medicare due to age or disability while you are an active employee, the benefits of your Company-sponsored medical plan will be paid before Medicare Part A and/or B benefits, except:

- For individuals who are entitled to Medicare due to chronic kidney disease (End Stage Renal Disease, or ESRD), your Company-sponsored medical plan will pay benefits before Medicare for the first 30 months of Medicare entitlement. After 30 months, Medicare Part A and Part B will become the primary payer and the Company-sponsored plan will become the secondary payer. Please notify Anthem Blue Cross or Kaiser Permanente Insurance Company (KPIC) as soon as ESRD is diagnosed.
- For individuals on Long-Term Disability (LTD) who are entitled to Medicare due to disability, and also for any Medicare-eligible dependents they cover, Medicare's Part A and B will become primary payers and the Company-sponsored plan will become the secondary payer. (Note: In 2013, LTD recipients are not covered on the Health Account Plan (HAP), but may be covered under other PG&E sponsored medical plans).

Medicare Reduction Applies Even If You Have Not Enrolled

If you or a covered dependent fall into one or both of the exceptions listed above, that individual must apply for and enroll in Medicare Parts A and B. The Company-sponsored medical plan's level of benefit coverage will not change but, because Medicare is the primary payer, the Company-sponsored plans will reduce its payment by the amount Medicare pays or should have paid had the individual enrolled for Parts A and B. Therefore, if you do not enroll in Medicare when eligible, you will be responsible for the portion of claims Medicare would have paid.

The Company will reimburse LTD employees for the full cost of the standard Part B premiums they pay for Medicare Part B coverage. In addition, the Company will reimburse LTD employees for the full cost of the standard Part B premiums they pay for any eligible disabled Medicare-covered dependents, until the dependent(s) reach age 65. However, you must be enrolled in a PG&E medical plan, provide a copy of your Medicare card to the HR Service Center, and request reimbursement of your Medicare part B premiums. PG&E will not issue reimbursement of Part B premiums on a retroactive basis, so it is important that you promptly send a copy of your Medicare card when you or your dependent(s) first obtain Part B coverage. The maximum number of reimbursements a family may receive for disabled members is three.

This means that all active employees enrolled in the Health Account Plan (HAP), except those as qualified above, should submit claims first to Anthem Blue Cross or KPIC. In addition, all active employees should notify Medicare of their primary coverage under any of the plans offered by the Company.

For Pacific Gas and Electric Company employees, the Company has retained the services of Allsup, Inc. to assist Long-Term Disability (LTD) recipients and early retirees in applying for Social Security disability benefits and enrolling in Medicare. These services are provided at no cost. If you are disabled and an LTD recipient or an early retiree, you can call Allsup, Inc. at 888-339-0743 to request assistance.

If you are receiving LTD benefits, your available medical plan options are described in the "Medical Coverage" section of the 2011 edition of the Summary of Benefits Handbook for employees represented by the IBEW, ESC and SEIU unions. However, please note that the Blue Shield and Health Net plans are no longer being offered after 2012.

Medicare Part D — Prescription Drug Benefits

Active employees and/or their dependents who are eligible for Medicare may not elect to enroll in Medicare's prescription drug benefits outside the Company — known as Medicare Part D Plans — while being covered under a Company-sponsored medical plan. The Company-sponsored medical plans all provide a prescription drug benefit equal to or better than Medicare's basic Part D benefit. Enrolling in a Medicare Part D Plan outside of the Company will result in your losing all medical and prescription drug coverage under the Company-sponsored plans. Every year, the Company provides a Creditable Coverage notice to all medical plan participants. The notice attests that the Company-sponsored medical plans' prescription drug benefits are actuarially equal to or better than the Medicare Part D basic benefit. You should keep the notice because it provides protection against Medicare Part D late enrollment penalties should you at sometime in the future drop your Company-sponsored medical plan coverage and enroll in a Medicare Part D Plan. For a copy of the notice or additional information, you can contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Medicare and Active Employment

Under the Tax and Equity Fiscal Responsibility Act of 1983 (TEFRA) and the Deficit Reduction Act of 1984 (DEFRA), the Company is required by law to offer employees or their spouses who are age 65 or older the same array of group health plans that are available to younger employees. TEFRA relates to an employee who will be turning 65 and DEFRA relates to a spouse/registered domestic partner who will be turning 65 and who is currently being covered as a dependent on the employee's coverage. Employees and their spouses/registered domestic partners have the option of choosing one of the Company-sponsored group health plans or Medicare as their primary plan.

Medicare Part A and B

If you elect a Company-sponsored plan as your primary plan, the Company-sponsored plan will continue to be the first payer for your coverage while you are an active employee of the Company. You have the option of signing up for Medicare Part B and having Part B as your secondary coverage; however, you may find you receive little value from your Part B benefits for which you are required to pay premiums. Thus, you may want to delay enrollment in Medicare Part B until you retire. To avoid penalties from the Social Security Administration, you must enroll in Medicare Part B within eight months of retirement from the Company. However, to receive maximum benefit from PG&E's retiree medical plans, you and your Medicare-eligible dependent(s) should enroll in Part B shortly before retiring so that your Part B coverage takes effect no later than your retirement date. Since Medicare Part A is free for most employees, you may enroll in Part A as soon as you are eligible, even if you are still an active employee.

If you elect Medicare as your primary plan while you are still actively working, Medicare will be your only group medical coverage; your Company-sponsored medical coverage will be dropped. The Company is legally precluded from offering you any Medicare supplemental coverage while you are still working. If you elect this option, you may find that your benefits will be less than what you would have received had you elected to keep your Company-sponsored plan as primary payer.

Prior to turning age 65, you or your spouse/registered domestic partner will be sent a TEFRA or DEFRA election form — whichever applies — to complete and return to the HR Service Center. If you do not return the form by the indicated date, the Company will assume that you plan to continue working and retain the same Company-sponsored plan that you are currently enrolled in as the primary plan for you and/or your Medicare-eligible dependent(s).

Reductions/Exclusions for Duplicate Coverage

If you are entitled to benefits from any of the following sources, plan benefits will be reduced by either the amount of actual benefits paid or the reasonable value of services provided by these sources:

- Benefits provided under Title 18 of the Social Security Act (Medicare). Plan benefits will be paid less the amount paid under Medicare.
- Benefits provided by any other federal, state or governmental agency, or by any county or other political subdivision, except for benefits from MediCal.
- Benefits to which you are entitled under Workers' Compensation or other similar laws.
- Benefits provided under any other health care service plan or HMO.
- Benefits provided under the extension of benefits provision of any group, blanket or franchise disability insurance policy, any other health care service plan, any hospital service plan, or any self-insured welfare benefit plan.

Subrogation and Reimbursement

The Plan has the right to recover 100% of the payments made or to be made on your behalf when you, your heirs, assigns, representatives or estate recover money or have the right to recover money from any of the following sources. These sources are called "Third Parties":

- Any person or entity alleged to have caused you to suffer sickness, injuries or damages, or who caused or is responsible for the sickness, injuries or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide health care benefits or payments to you, including health care benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, medical malpractice coverage, or coverage by other insurance carriers or third-party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal theory.

The Plan may obtain recovery through subrogation, reimbursement, refunds of overpayments or through any other available legal theory. The right of recovery applies regardless of whether you have been fully compensated for your injuries or condition.

Subrogation is the substitution of one person or entity in place of another with reference to a lawful claim, demand or right. The Plan will be subrogated to and shall succeed to all rights of recovery that you may have against a Third Party under any legal theory of any type for 100% of the benefits that the Plan provides to you or will provide to you. In addition to any subrogation rights and in consideration of the coverage provided by the Plan, the Plan also has an independent right to be reimbursed by you for 100% of the benefits the Plan provides to you or will provide to you.

You agree as follows:

- That you will cooperate with the Plan and its Claims Administrators in a timely manner in protecting the Plan's legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - notifying the Plan's Claims Administrators in writing as soon as you learn that a Third Party may be liable for causing your need for health care benefits,
  - providing any relevant information requested by the Plan or its Claims Administrators,
  - signing and/or delivering such documents as the Plan or its Claims Administrators reasonably request to secure the subrogation and reimbursement claims,
  - responding to requests for information about any sickness, accident or injuries,
  - appearing at legal proceedings such as depositions and in court, and
  - obtaining the consent of the Plan or its Claims Administrators before releasing any party from liability of payment of health care expenses.
- That failure to cooperate in this matter will be deemed a breach of contract, and as such the Plan has the right to terminate health care benefits and/or institute legal action against you. If the Plan incurs attorney's fees and costs in order to enforce its rights of subrogation and reimbursement, it has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been paid to the Plan.
- That the Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without express written consent from the Plan or Claims Administrators; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" will not defeat this right, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.

- That regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment no matter how those proceeds are captioned or characterized. The proceeds available for collection will include, but are not limited to, any and all amounts earmarked as economic, non-economic and punitive damages, whether in the form of settlements or judgments. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine" claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- That the health care benefits paid by the Plan or its Claim Administrators may also be considered to be health care benefits advanced.
- That you agree that if you receive any payment from any Third Party or an insurer as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds received from any Third Party that are due and owed to the Plan, as stated herein, separately and alone (e.g., in a separate bank account or in your attorney's trust account), and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health care benefits or the institution of legal action against you.
- That you will transfer title to the constructive trust to the Plan for all health care benefits that have been paid or will be paid as a result of your sickness, injury or illness.
- That the Plan will be entitled to recover reasonable attorney fees from you that are incurred in collecting from you any funds held by you that you recovered from any Third Party.
- That the Plan may offset from any future health care benefits otherwise allowed the value of health care benefits paid or advanced under this section to the extent not covered by the Plan.
- That you will neither accept any settlement that does not fully compensate or reimburse the Plan without the written approval of the Plan or its Claims Administrators, nor will you do anything to prejudice the Plan's rights under the provision.
- That you will assign to the Plans all rights of recovery against Third Parties, to the extent of the reasonable value of services and health care benefits the Plan provided, plus reasonable costs of collection.
- That the Plan's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom you are seeking recovery, to be paid before any other of your claims are paid. Further, the first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment centers, that assert a right to payment from funds payable from or recovered from an allegedly responsible or responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements or judgments or other recoveries paid or payable to you or your representative on your behalf no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic and punitive damages, whether in the form of settlements or judgments. The Plan is not required to help you to pursue your claim for damages or personal injuries and no court costs or attorneys' fees may be deducted from our recovery without express written consent from the Plan or Claims Administrators; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" will not defeat this right.
- That the Plan's rights will not be reduced due to your own negligence.
- That the Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation and reimbursement provisions, including but not limited to providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party, and/or filing suit in your name, which does not obligate the Plans in any way to pay you part of any recovery the Plans might obtain.
- That the Plan shall not be obligated in any way to pursue this right independently or on your behalf.

- That if the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section also applies to the parents or guardian of the minor child.
- That in the case of a wrongful death, this section also applies to your estate, personal representative of your estate, and your heirs, legatees or beneficiaries.
- That if the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Plan Participant, also called "member," this section will apply to any personal representative of the Plan Participant.
- If a third party causes or is alleged to have caused you to suffer a sickness, injury or damages while you are covered under the Plan, the provisions of this section will continue to apply, even after you are no longer covered.
- The Plan and the Plan Administrator (or the Claims Administrators acting on their behalf) have the authority and discretion to resolve all disputes regarding the interpretation of the language contained in these provisions, and shall have the such powers and duties as are necessary to discharge their duties and functions, including the discretionary authority to (1) construe and enforce the terms of these subrogation and reimbursement provisions and rights, and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

For KPIC Members Only

Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to:

Harrington Health
3701 Boardman-Canfield Rd., Bldg B
Canfield, OH. 44406-7005

In order for the Plan to determine the existence of any rights the Plan may have and to satisfy those rights, you must complete and send all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay the Plan directly. You may not agree to waive, release, or reduce the Plan's rights under this provision without the Plan's prior written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plan's liens and other rights to the same extent as if you had asserted the claim against the third party. The Plan may assign its rights to enforce liens and other rights.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare, Workers' Compensation or employer's liability benefits.

You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. The Plan will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but the Plan may recover the value of any covered Services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due, and
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

When Coverage Ends

Your health care coverage under the health plans for active Management and Administrative & Technical employees will continue until the end of the month in which:

- you terminate your employment for any reason, including retirement (see "You Retire" in the *What If...* section);
- you are no longer in a union-represented position;
- you fail to pay your share of the cost of coverage. If you are billed monthly in advance, you will have no coverage for any month in which you fail to pay your share of the coverage cost; or
- the plan terminates.

Continuing Coverage with COBRA

When coverage ends, you and your covered dependents may be eligible to continue your existing benefits under the COBRA Continuation Program or convert your medical coverage to an individual policy. Please see "Conversion to an Individual Medical Policy" on page 114 for more information on continuing coverage that has ended.

Also see "Extended Benefits When Coverage Ends" on page 107 and "If You Retire or Leave the Company" under "What Happens" in the *Flexible Spending Account* section.

Your Dependents

Your dependents' coverage will end when your coverage ends, or on the last day of the month in which they no longer qualify as Eligible Dependents. If you become legally separated or divorced, or if your registered domestic partnership ends, the coverage of your former spouse/registered domestic partner and his or her children (including step-children, unless you have adopted them) will end on the last day of the month in which the legal separation, divorce or termination of registered domestic partnership becomes final. You may, however, continue to cover your registered domestic partner's children if those children were born or adopted during the period of your registered partnership. You must notify the HR Service Center within 31 days of the effective date of divorce, legal separation, termination of a registered domestic partnership or a dependent's loss of eligibility. Also see "Extended Benefits When Coverage Ends" on page 107.

Extended Benefits When Coverage Ends

Hospitalization

If you or a covered dependent is hospitalized at the time coverage ends, the Health Account Plan (HAP) will continue benefits for the same illness until the earlier of the following events:

- You or your covered dependent has recovered sufficiently to be discharged from the hospital by your doctor; or
- The maximum plan benefits have been paid.

Disability

If you or a covered dependent is "totally disabled" when your coverage ends, the HAP will continue benefits for treatment of the disabling condition for up to 12 months. For purposes of the HAP, in the case of an employee, "totally disabled" means you are unable to perform the tasks of any employment or occupation for which you are qualified. In the case of a dependent, "totally disabled" means being unable to perform all the regular and customary activities for a person of that age.

Benefits will end before the 12-month period if you or your dependent:

- cease to be totally disabled;
- fail to furnish satisfactory proof of continuing disability as required by the plan;
- receive maximum benefits from the plan; or
- become covered for the disabling condition under any other group health plan.

To be eligible for these extended benefits, your attending physician must certify the disability in writing and submit this statement within 90 days of the date on which coverage would otherwise end. Written proof of the continuing disability will be required every 90 days during the period for which extended benefits are available.

Extended Dental Benefits

If you or a covered dependent is undergoing a dental procedure (a "single procedure") when your Company-sponsored dental coverage ends, the Dental Plan will continue to pay benefits for any single procedures which began while you were still eligible. A single procedure is defined as a dental procedure to which a separate procedure number is assigned. The single procedure must have actually begun before you lost eligibility. Planning future dental work with your dentist or obtaining a predetermination, in itself, will not qualify you for extended dental benefits. Orthodontic care or other treatment plans are not considered single procedures because the care consists of a number of separate procedures.

Continuing Coverage Under COBRA

If your Company-sponsored health care coverage ends, you and your covered dependents may be eligible for continued benefit coverage through COBRA.

In addition, you may be able to convert your medical plan coverage to an individual medical plan policy. You also have the option to contact an independent insurance broker to obtain individual medical coverage. See "Conversion to an Individual Medical Policy" on page 114.

Don't Miss the Deadlines!

There are very specific timelines and enrollment requirements that must be followed in order to obtain COBRA continuation coverage. It is important that you and your covered Eligible Dependents read all the information that is provided regarding COBRA continuation coverage. If you or your dependents have questions about COBRA coverage, you and your dependents are encouraged to call Ceridian Benefits Services at 800-877-7994, send an email to cobrasupport@ceridian.com, or visit Ceridian's Web site at www.ceridian-benefits.com.

COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal law, allows you and/or your covered Eligible Dependents to continue participation in the Company-sponsored group health plans (including the Company-sponsored medical, dental, vision, prescription drug, mental health and substance abuse benefits, the Health Care Flexible Spending Account, and the Employee Assistance Program) beyond the normal period if you have lost these coverages because of the occurrence of one of the qualifying events described under Eligibility in this section. Medical plan options are based on the qualified beneficiary's residence ZIP code. Obtaining coverage through COBRA is at your own cost and may continue for a period of up to either 18 or 36 months, depending on the qualifying event and type. If you elect continued coverage through COBRA, benefits will be identical to your current coverage; any subsequent changes in the plans for active employees will also apply to you.

Certificates of Creditable Coverage

You or your dependents may need to provide a subsequent employer or health plan with proof that you previously had coverage under the Company-sponsored health plans. This proof may allow you to avoid or reduce a preexisting condition exclusion period under another plan or otherwise help you enroll in another plan. When you and/or your dependents lose medical coverage under a Company-sponsored health plan, your medical provider will send you a "certificate of creditable coverage" showing proof of your prior health coverage. This certificate will state the period of time you and your dependents were covered under the Company-sponsored health plan, including coverage through COBRA, and a statement about your rights under the Health Insurance Portability and Accountability Act (HIPAA). Please keep the "Certificate of Creditable Coverage" with your personal records.

You or your dependents may request a Certificate of Creditable Coverage while you are enrolled in a Company-sponsored health plan or within 24 months after your coverage ends by contacting your medical coverage provider.

Eligibility

You and your covered dependents who meet the definition of a "qualified beneficiary" (see the definition of a qualified beneficiary below) may be eligible for continued health care coverage through COBRA if a "qualifying event" occurs as explained here. Each individual who meets the definition of a qualified beneficiary is entitled to make separate elections regarding continued coverage through COBRA.

Definition of a Qualified Beneficiary

A qualified beneficiary is an individual who is enrolled as one of the following under the Company-sponsored group health plan on the day before a qualifying event occurs:

- an employee or retiree;
- the spouse of a covered employee or retiree; or
- an Eligible Dependent child of a covered employee or retiree.

If you have a child born to or adopted by you while you are covered through COBRA, your newborn or adopted child will also be considered a qualified beneficiary, as long as you add the child to your COBRA coverage within 180 days of birth or adoption.

Please note: Qualified beneficiary status is forfeited if an individual declines COBRA coverage when he or she is first eligible, even if the individual is later added to your COBRA coverage as a covered dependent during an offered COBRA Open Enrollment period.

Registered Domestic Partners

Registered domestic partners and their children are not covered by COBRA. However, the Company extends the same type of coverage rights to registered domestic partners and their children which it would extend to qualified beneficiaries under COBRA. Qualifying events to obtain this COBRA-like coverage are the same as those for spouses under COBRA, including the dissolution of a registered domestic partnership, and are also administered by Ceridian Benefit Services.

Qualifying Events

18-Month Events

You and your covered dependents who are qualified beneficiaries have the option to continue coverage for up to 18 months, calculated from the loss of coverage date, by paying the required premiums from the date on which coverage would otherwise end, if one of the following qualifying events occurs:

- your employment with the Company terminates for any reason (including voluntary resignation or retirement) other than gross misconduct;
- your Company-sponsored group health coverage would otherwise end due to a reduction in your work hours; or
- your employment with the Company terminates during or at the end of an approved leave of absence from the Company (including personal or medical leaves of absence, military leaves and leaves that qualify under the California Family Rights Act of 1991 and/or the federal Family and Medical Leave Act); or

36-Month Events

Your covered dependents who are qualified beneficiaries have the option to continue coverage for up to a total of 36 months, calculated from the initial loss of coverage date, by paying the required premiums from the date on which coverage would otherwise end, if one of the following qualifying events occurs:

- your death occurs while being covered as a plan participant (your eligible covered dependents have a choice of continuing their coverage under COBRA or under the Survivor Medical Benefits offered by the Company for surviving dependents of Company employees — see "Medical Benefits for Survivors of Active Employees" under "You Become Terminally Ill or Die While an Active Employee" in the *What If...* section.);
- you and your spouse become divorced or legally separated; or
- your dependent child no longer qualifies as an Eligible Dependent under the Company-sponsored plans.

Spouse and Dependent Elections

Please note that if one of the 36-month qualifying events occurs while you and your dependents are covered on an 18-month COBRA continuation period, your spouse and/or Eligible Dependent children who are qualified beneficiaries may elect to continue coverage under COBRA for up to 36 months from the date of the first qualifying event, which is the date you first lose coverage. (Note: even if you do not elect COBRA continuation coverage, your spouse and covered dependents who elected COBRA may still be eligible for a second qualifying event.)

Domestic Partners

Registered domestic partners and their children are not covered by the COBRA law. However, the Company extends the same type of coverage to registered domestic partners and their children that it would extend to qualified beneficiaries under COBRA. Qualifying events to obtain this COBRA-like coverage are the same as those for spouses under COBRA, including the dissolution of a registered domestic partnership, and are also administered by Ceridian Benefit Services.

Additional Event

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the company from which the individual retired, and that bankruptcy results in the loss of coverage of any retired employee covered under the group health care plans within certain time periods, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse or registered domestic partner, surviving spouse or registered domestic partner, and dependent children and/or children of your registered domestic partner will also become qualified beneficiaries if bankruptcy results in the loss of their group health care coverage.

Important: Dropping Dependents During Open Enrollment

Qualified dependents must be covered under your plan at the time of the actual qualifying event. Dependents who are dropped during the Open Enrollment process may not qualify for continued coverage under COBRA since COBRA rights are only triggered by certain qualifying events which occur while the individual is enrolled under the Company-sponsored plans. In addition, you must notify the HR Service Center of the qualifying event within a specific time frame.

If you drop a dependent during the Open Enrollment period and believe your dependent is eligible for COBRA due to a qualifying event which has occurred, please contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363. COBRA rights may be jeopardized if contact with the HR Service Center is not made within the later of 60 days of the qualifying event or 60 days from the date that benefits would terminate under the plan as a result of the qualifying event.

Employees who are considering or in the process of obtaining a divorce or dissolution of a registered domestic partnership should consult with their personal legal advisors before discontinuing coverage for their dependents. If you drop your dependents' coverage during Open Enrollment and the divorce or dissolution is finalized at a later date, your dependents may not be able to obtain medical coverage through COBRA, although you may continue to be financially responsible for your dependent's medical care.

How Medicare Entitlement Affects Your COBRA Eligibility

If you are an employee who becomes entitled to Medicare prior to the date you are eligible to elect COBRA as a result of either your termination of employment or a reduction of work hours, you are eligible to continue your Company health care coverage for 18 months from the date of your termination of employment or reduction in work hours. Your covered dependents who are qualified beneficiaries are eligible to continue coverage for either (1) up to 36 months from the date on which you became entitled to Medicare (which was a date prior to the date on which you lost health care coverage due to termination of your employment or a reduction in your work hours) or (2) up to 18 months from the date on which your employment terminates or you lose health care coverage because of a reduction of work hours, whichever period provides longer coverage.

Please note that if you are already covered through COBRA for an 18-month period when you become entitled to Medicare, your medical coverage under COBRA will end when you become entitled to Medicare, although your dependents may continue coverage until the end of the 18-month period.

Extension of COBRA Coverage Due to Disability

You and your qualified beneficiaries may elect a special 11-month extension of COBRA coverage for a total of up to 29 months from the date of the initial qualifying event, the date you first lose coverage, if:

- you are already covered through COBRA for an 18-month coverage period; and
- you or your qualified beneficiary is disabled as determined by Social Security when:
  - your employment terminates; or

- your benefits are lost due to a reduction in work hours; or
- you are still within the first 60 days of your 18-month COBRA continuation period.

To qualify for this extension, you must notify Ceridian Benefits Services, the third-party COBRA administrator, at 800-877-7994 within the following time frames:

- within 60 days of the date of the Award Notice from the Social Security Administration on which Social Security makes a determination that you or your qualified beneficiary is disabled; and
- before the end of your initial 18-month COBRA coverage period.

If Social Security makes a determination of disability prior to the date of your termination or reduction in work hours which results in the end of your health care coverage, then you must notify Ceridian Benefits Services of the disability within 60 days of the date of your qualifying event or benefit termination date, whichever is later. You must also notify Ceridian Benefits Services) within 30 days of the date on which Social Security determines that you or your qualified beneficiary is no longer disabled.

Extended COBRA coverage for disabilities will end on the earliest of:

- the first day of the month after Social Security determines that you or your dependent are no longer disabled; or
- the date specified under When COBRA Coverage Ends.

When COBRA Coverage Ends

In general, your coverage continued through COBRA will remain in force for the periods described in this section. However, COBRA coverage will end before the maximum time periods if:

- you fail to pay the required premium when due (failure to meet COBRA's payment deadline — even by a day — will end your COBRA coverage and you will not be able to re-enroll);
- you or your dependents become entitled to Medicare (Medicare entitlement terminates all coverage only for the individual covered by Medicare);
- you obtain other group health coverage and the other group health coverage does not impose a preexisting condition exclusion which applies to a preexisting condition that you have;
- your dependent obtains other group health coverage and the other health plan coverage does not impose a preexisting condition exclusion which applies to a preexisting condition that your dependent has;
- your or your dependent's coverage is terminated for cause, such as submitting false claims;
- the Company-sponsored group health care plans are terminated.

Note: You must notify Ceridian Benefits Services at 800-877-7994 if you become covered by another group health plan.

Enrollment in the Health Care Flexible Spending Account will terminate at the end of the year in which your COBRA began. Please refer to More About Flexible Spending Accounts in the section entitled Flexible Spending Accounts for further details.

Cost of COBRA Continuation Coverage

You and your dependents must pay the cost of COBRA coverage during an 18- or 36-month COBRA period, if you elect coverage. You will pay 100% of the full cost of coverage, plus a 2% administrative charge, for each plan you elect to continue — medical (which includes prescription drug, mental health and substance abuse coverage), dental, vision, Health Care Flexible Spending Account, and/or the Employee Assistance Program.

The cost of COBRA coverage during the 19th through the 29th month of a disability extension will be 150% of the full cost of coverage for each month, plus a 2% administrative charge.

You must pay for COBRA coverage on a monthly basis. You must make your first payment within 45 days after the date on which you elect COBRA coverage. The first payment will include the cost of coverage retroactive to the first day of the month immediately after the date on which your Company-sponsored coverage would otherwise end. Subsequent payments are due the first day of each month. However a grace period of 30 days will be provided. Payments must be made by the grace date. Please note that claims will not be paid until after you have made all COBRA payments that are due through the date on which the health care expense was incurred.

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 800-977-7994.

How to Obtain COBRA Continuation Coverage

If you get divorced or legally separated, dissolve a registered domestic partnership, or if your dependent child no longer qualifies as an Eligible Dependent under the plans, you must call the HR Service Center within 31 days of the eligible change-in-status event (180 days for births or adoptions). To request COBRA enrollment materials, you must call within 60 days of the occurrence of the COBRA-qualifying event or the last day of eligible coverage — whichever occurs last.

If you lose health coverage or upon your death, the HR Service Center will automatically provide you or your dependents with COBRA enrollment materials.

Dependents who are dropped during the Open Enrollment process may not qualify for continued coverage under COBRA, since these rights are only triggered by certain qualifying events and specific notification to the Company. If you are dropping a dependent during the Open Enrollment period and are unsure whether or not the dependent is eligible for COBRA due to a qualifying event, please contact the HR Service Center.

The required COBRA forms must be completed and returned to Ceridian Benefits Services within 60 days from the date on which coverage would otherwise end or from the date on which the election forms are sent by Ceridian Benefits Services, whichever is later. If you or your Eligible Dependents do not file the COBRA election forms within this 60-day period, COBRA rights will be forfeited and your group health coverage will end effective the last day of the month in which the qualifying event occurred.

If you need to report the occurrence of a qualifying event or if you have any questions about whether or not a dependent is eligible for COBRA continuation coverage, contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363. Be sure to let the HR Service Center know the address to which any COBRA packages should be sent.

To obtain complete details of the terms and conditions of continued coverage through COBRA or to request the required COBRA forms to elect COBRA coverage, contact Ceridian Benefits Services at 800-877-7994.

Review of COBRA Determination of Ineligibility

If you believe you have been denied a benefit to which you may be entitled due to eligibility for or enrollment in COBRA, you may request a review by Ceridian Benefits Services, the third-party Claim Administrator at:

Ceridian Benefit Services
COBRA Compliance Department
3201 34th Street South
St. Petersburg, FL 33711-3828

Eligibility Appeals

If you are not satisfied with the results of Ceridian's review, you may formally appeal in writing to the Plan Administrator.

You have 90 days from the date on which you receive a determination from Ceridian to write to the Benefits Department and indicate that you are appealing Ceridian's decision. You should include all relevant information in your appeal. 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 **Human Resources Forms** section of the PG&E@Work intranet or by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Send your appeal to:

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

The Benefits Department will review your appeal and will make a decision within 60 days of the date on which the appeal is received (non-receipt of the HIPAA Authorization may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if the Benefits Department determines that an extension is necessary.

If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial;
- a reference to the Plan provision(s) that apply to the denial; and
- an explanation of additional appeals procedures.

If you are not satisfied with the Benefit Department's decision, you may then submit a written appeal for review (within 90 days of receiving the Benefits Department's notice of denial) to the Employee Benefit Appeals Committee (EBAC), the final decision maker in the appeals process, stating the reasons for your appeal and enclosing all documentation and any additional information to support your appeal.

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.

Send your appeal to:

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

You will receive a final ruling from the EBAC within 90 days of the EBAC's receipt of your appeal unless, due to special circumstances, the EBAC requires additional time to respond, up to another 90 days.

If the 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; 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.; and
- a statement of your right to bring civil action under section 502(a) of ERISA.

Conversion to an Individual Medical Policy

You may be eligible to convert (change) your group medical plan coverage to an individual insurance policy, at your own expense. This is called the conversion privilege. The cost and benefits provided under the converted medical policy, however, are different than those provided by your Pacific Gas and Electric Company-sponsored medical plan.

Ordinarily, you have 31 days from the date on which your Pacific Gas and Electric Company-sponsored medical coverage ends to apply for a converted policy and pay the first premium. However, if you opt to continue your medical coverage under COBRA as explained under Coverage Through COBRA, you may convert to an individual policy within 31 days of the end of the maximum 18-, 29- or 36-month COBRA period.

The conversion privilege may also be available to your covered Eligible Dependents in the following instances when:

- your dependent child no longer qualifies as an Eligible Dependent under the Company-sponsored plans;
- you and your spouse become divorced or legally separated;
- you and your registered domestic partner no longer meet the registered domestic partnership criteria or end your registered domestic partnership; or
- your death occurs and your surviving spouse/registered domestic partner and/or dependent child(ren) were covered before your death, and they do not continue medical plan coverage through the Pacific Gas and Electric Company's Survivor Medical Benefits nor do they elect to continue their group coverage under COBRA, as explained under Coverage Through COBRA.

Please note that Anthem HAP members are not eligible for a converted medical insurance policy if PG&E-sponsored coverage ended due to non-payment of monthly contributions.

Just as with continuing your coverage through COBRA, you do not have to show that you are insurable to exercise the conversion privilege. It is important to note, however, that the individual policy offered by your medical plan carrier through the conversion privilege may provide different benefit coverage than that which you had under the Company-sponsored medical plan or that which you would be able to continue through COBRA, if eligible. The cost of a converted medical policy may also be considerably higher than that which you would pay to continue the Company-sponsored coverage through COBRA. Thus, you may also want to consider other alternatives which may be available to you.

Please check with Anthem Blue Cross or KPIC, as appropriate, to learn more about conversion rights, benefits coverage and cost. You also have the option to contact an independent insurance broker or the provider to obtain individual medical coverage.

The dental, vision, and prescription drug plans, the Mental Health and Substance Abuse Program, the Health Care Flexible Spending Account, and the Employee Assistance Program do not offer conversion to individual policies.

Medical Coverage

Whether you have just joined the Company and are enrolling in a Company-sponsored medical plan for the first time or you are considering changing your existing medical coverage, you should evaluate the medical plan options based on your needs and experience. Be sure to consider your future as well as your present medical needs when selecting your plan.

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation. The plans and benefits described in this section are also applicable to employees of designated subsidiaries and affiliates, but only to the extent that such entities are participating employers with respect to the described plans or programs and such employees meet the eligibility requirements of the plans or programs.

When you first begin working at the Company, you will be eligible to enroll in a medical plan (described in the *Health Care Participation* section) and elect coverage for your Eligible Dependents. Your medical coverage elections for you and your Eligible Dependents begins on the first day of the month following receipt of your elections, provided you complete and return an enrollment form within 31 days of your date of hire or transfer into a union-represented employee position. For example, if you were hired on February 1 and you return a completed form on February 15, you would be eligible for health care benefits for you and any Eligible Dependents you choose to cover on March 1.

New hires who do not enroll within 31 days will be required to wait until the next Open Enrollment period to enroll, with coverage effective January 1 of the following year.

Depending on where you live, you are eligible to enroll in one of the following two medical plan options: the Health Account Plan (HAP) administered by Anthem Blue Cross (the Anthem HAP) or the Health Account Plan (HAP) administered by Kaiser Permanente Insurance Company (the KPIC HAP). As an alternative, you may elect to decline ("opt out of") medical coverage.

You are not eligible for medical coverage if you are a contract worker, agency worker, or hiring hall employee. Intermittent employees and other temporary employees who are not expected to become regular employees are also not eligible for coverage.

The Health Account Plan (HAP)

This section describes the Health Account Plan (HAP). Depending on where you live, you may choose Anthem Blue Cross or KPIC to be your administrator for the Health Account Plan (HAP).

In This Section — See Page

The HAP at a Glance

This is a summary of the Health Account Plan (HAP) benefits. Please refer to "What the HAP Covers" on page 142 for more information on covered services and exclusions.

The information in these charts is intended to be a summary of the benefits provided by the HAP as of January 1, 2014. The information contained in the applicable service provider agreements between The Pacific Gas and Electric Company, Anthem Blue Cross, (referred to as "Anthem" in this document) and Kaiser Permanente Insurance Company (referred to as "KPIC" in this document) shall govern in case of conflict between this chart and the service provider agreements. Please refer to the most recent information about your medical plan benefit options, which are updated annually in the Open Enrollment materials.

Health Account Plan (HAP) Benefits for Anthem and KPIC Members	
Provision	
General	Annual deductible: ▪ $1,000/person; $2,000/family Annual out-of-pocket maximum (includes deductible): ▪ $2,400/person; $4,800/family Coinsurance: ▪ You pay 10% for primary care (beyond four free visits) with no deductible. ▪ You pay either 10% or 20% coinsurance depending on the type of provider and service. ▪ You pay no coinsurance for preventive care. For KPIC members, preventive care includes all services defined within the Kaiser National Preventive List. No lifetime benefits maximum except for infertility services. No pre-existing condition exclusions.
	▪ All plan benefits and out-of-pocket maximums are based on eligible expenses only. For the definition of "eligible expenses," see the "Glossary" on page 174. ▪ Both network and non-network covered expenses apply to deductible and out-of-pocket limits. ▪ Family deductible and out-of-pocket limits can be met by any combination of family members. Any family member can reach the single annual deductible and the plan will start to pay benefits for that person, even if the family annual deductible has not yet been met.

Health Account Plan (HAP) Benefits for Anthem and KPIC Members	
Hospital Stay	▪ You pay 20%, subject to deductible; expenses apply to out-of-pocket maximum. ▪ For the Anthem HAP: ▫ pre-authorization is required. ▫ Out-of-network hospital-based physicians' services at in-network facility allowed at billed charges. ▪ For the KPIC HAP, your network physician will request pre-authorization.
Skilled Nursing Facility	▪ You pay 20%, subject to deductible; expenses apply to out-of-pocket maximum. ▪ No day maximum. ▪ For the Anthem HAP, pre-authorization is required
Emergency Room	▪ You pay 20% for emergency room and physician, subject to deductible; expenses apply to out-of-pocket maximum. ▪ Accidental injury and medical emergency diagnosis pay as emergency. ▪ Services billed by a provider other than the hospital will be paid according to the appropriate benefit category level. ▪ For the Anthem HAP, out-of-network hospital-based physicians' services at in-network facility allowed at billed charges. ▪ For the KPIC HAP: out-of-network urgent and emergent care allowed at billed charges. There is a charge for same day and same condition visits.
Outpatient Hospital Care	▪ You pay 20% for outpatient hospital care (including surgery, chemotherapy, radiation and dialysis services), subject to deductible; expenses apply to out-of-pocket maximum.
Maternity Care (professional)	▪ Routine pre-natal and post-natal visits are free. ▪ You pay 20% after deductible for screenings and tests (for example, sonograms). ▪ You pay 20% after deductible for delivery. ▪ Includes nurse midwives, but excludes lay midwives and doulas (for the KPIC HAP, services must be received from network providers).
Well-Baby Care	▪ Fully covered (no deductible) up to age two.
Women's Preventive Care	▪ For Anthem HAP members: Birth control and contraceptive devices on the HAP Free Drug List are fully covered (no deductible) if obtained through mail-order (if purchased at a retail pharmacy, retail coinsurance applies). ▪ For KPIC HAP members: With a prescription, birth control and contraceptive devices fully covered (no deductible) at retail and mail order. Without a prescription, retail cost will be charged for retail purchases. ▪ Contraceptive counseling, and implantable and injectable contraceptives fully covered (no deductible). ▪ Voluntary sterilization fully covered (no deductible).

Health Account Plan (HAP) Benefits for Anthem and KPIC Members	
Office Visits	▪ First four visits to a primary care physician (includes general or family practice, internal medicine, pediatrics, family nurse practitioner, obstetrics and gynecology) fully covered (no deductible) (employee and each enrolled dependent); if one of first four visits is a physical exam, this counts toward the four free visits; you pay 10% for all subsequent visits, not subject to deductible; expenses apply to out-of-pocket maximum. ▪ Includes medically necessary non-routine vision and hearing care. ▪ For the Anthem HAP, the primary care physician (PCP) must be trained as a generalist for member to qualify for free visits. ▪ You pay 20% for all specialist office visits, subject to deductible; expenses apply to out-of-pocket maximum.
Urgent Care Visits	▪ Included as part of the four free visits to a PCP (employee and each enrolled dependent); you pay 10% for all subsequent visits, not subject to deductible; expenses apply to out-of-pocket maximum.
Routine Physical Examinations	▪ Free. ▪ Includes routine preventative gynecological exam.
Immunizations and Injections	▪ You pay 20% for injections, subject to deductible; expenses apply to out-of-pocket-maximum. ▪ Age-/gender-specific routine adult and child immunizations and approved travel immunizations are fully covered (no deductible), up to the maximum dollar limit.
Routine Eye Examinations	▪ For Anthem HAP members: not covered (for details on routine vision coverage offered to employees, see the *Vision Coverage* section). ▪ For KPIC HAP members: you pay 20%, subject to the deductible; expenses apply to out-of-pocket maximum.
X-rays and Lab Tests	▪ Most preventive X-ray and lab tests, including those on the free list, are fully covered (no deductible). ▪ You pay 20% for all other procedures, including diagnostic tests, subject to deductible; expenses apply to out-of-pocket maximum.
Home Health Care and Home Hospice Care	▪ You pay 20% for home health care, subject to deductible; expenses apply to out-of-pocket maximum. ▪ For the Anthem HAP: precertification required. ▪ For the KPIC HAP: your network physician will request pre-authorization. ▪ Includes home infusion therapy and nursing care. ▪ Hospice care fully covered (no deductible). ▪ Home health care not covered while covered person receives hospice care. ▪ Excludes custodial care.
Outpatient Physical/Occupational/Speech Therapy	▪ You pay 10% for first five visits and 20% for all subsequent visits, subject to deductible; expenses apply to out-of-pocket maximum. For purposes of determining coinsurance rates, tallying of the first five visits does not begin until the deductible has been met. ▪ Not combined with any other therapy. ▪ All visits may be reviewed for medical necessity; for the Anthem HAP, precertification is required for all visits beyond the 24th visit in a calendar year.

Health Account Plan (HAP) Benefits for Anthem and KPIC Members	
Outpatient Prescription Drugs	▪ You pay 15% for up to 30-day supply of formulary generic for Anthem Blue Cross members, up to 100-day supply for KPIC members, subject to deductible, at retail/pharmacy; for Anthem Blue Cross members, maximum of two refills at retail for maintenance drugs, and then mail order must be used. No mandatory mail order for KPIC members. ▪ You pay 25% for up to 30-day supply of formulary brand for Anthem Blue Cross members, up to 100-day supply for KPIC members, subject to deductible, at retail/pharmacy; for Anthem Blue Cross members, maximum of two refills at retail for maintenance drugs, and then mail order must be used. No mandatory mail order for KPIC members. ▪ You pay 10%, subject to deductible, for up to 90-day supply of generic at mail order for Anthem Blue Cross members; up to 100-day supply for KPIC members. ▪ You pay 20%, subject to deductible, for up to 90-day supply of brand at mail order for Anthem Blue Cross members; up to 100-day supply for KPIC members. ▪ Expenses apply to out-of-pocket maximum. ▪ Certain preventive drugs fully covered (no deductible) at mail order only for Anthem Blue Cross members. ▪ Certain preventive drugs fully covered (no deductible) at either a Kaiser Permanente pharmacy or mail order for KPIC members. Certain over-the-counter drugs fully covered (no deductible) at either a Kaiser Permanente pharmacy or mail order for KPIC members with a prescription. Without a prescription, Participant pays retail cost. ▪ Anthem HAP members: Generic Incentive Provision and Step Therapy Provision apply. See "Prescription Drug Coverage" on page 165 for more information.
Inpatient and Outpatient Mental Health Care	▪ You pay 20% for inpatient care, subject to deductible; expenses apply to out-of-pocket maximum. Pre-authorization required; $300 penalty for Anthem HAP members who fail to obtain pre-authorization. ▪ You pay 10% for outpatient care, not subject to deductible; expenses apply to out-of-pocket maximum. See "Mental Health and Substance Abuse Coverage" on page 155 for more information.
Inpatient and Outpatient Substance Abuse	▪ You pay 20% for inpatient care, subject to deductible; expenses apply to out-of-pocket maximum. Pre-authorization required; $300 penalty for Anthem HAP members who fail to obtain pre-authorization. ▪ You pay 10% for outpatient care, not subject to deductible; expenses apply to out-of-pocket maximum.
DOT- or NRC-Mandated Alcohol/Substance Abuse Treatment	▪ Fully covered (no deductible). ▪ Requires authorization by ValueOptions or an on-site EAP counselor.

Health Account Plan (HAP) Benefits for Anthem and KPIC Members	
Durable Medical Equipment (Purchase & Rentals), Prosthetics and Orthotics	▪ You pay 20%, subject to deductible; expenses apply to out-of-pocket maximum. ▪ For the Anthem HAP, precertification is required for purchase or cumulative rental exceeding $1,000. ▪ Includes colostomy/ostomy and urological supplies. ▪ Breast feeding pumps are fully covered (no deductible). For Anthem HAP members: Pump must be purchased from a Durable Medical Equipment provider, not a retail store, in order for the equipment to be free. Call your HAP administrator (Anthem or Kaiser) for details.
Chiropractic Care	▪ You pay 10% for first five visits and 20% for all subsequent visits, subject to deductible; expenses apply to out-of-pocket maximum. For purposes of determining coinsurance rates, tallying of the first five visits does not begin until the deductible has been met. ▪ All visits may be reviewed for medical necessity; if you are in Anthem HAP, precertification is required for all visits beyond the 5th visit in a calendar year.
Acupuncture	▪ You pay 10% for first five visits and 20% for all subsequent visits, subject to deductible; expenses apply to out-of-pocket maximum. For purposes of determining coinsurance rates, tallying of the first five visits does not begin until the deductible has been met. ▪ All visits may be reviewed for medical necessity; if you are in Anthem HAP, precertification is required for all visits beyond the 5th visit in a calendar year.
Other Benefits	▪ Infertility treatment services are covered. You pay 20%; subject to deductible; expenses apply to out-of-pocket maximum. Lifetime maximum of $7,000. You pay 50% for infertility drugs; subject to deductible; expenses apply to out-of-pocket maximum at retail/pharmacy. ▪ Transplants – You pay 20% after deductible for organ, stem cell and bone marrow transplants and bone marrow donor search services (unrelated family member), $30,000 maximum per search; travel and lodging for transplants covered at 100%, up to $10,000; bone marrow donor services and transplants performed at non-approved facilities for Anthem members, or by non-network providers for KPIC members are not covered. ▪ You pay 20% for hearing aids and exams to determine the need for hearing aids or the need to adjust them. You pay 20% for cochlear implants for adults and children (age 2 or older), for the following diagnoses: (1) severe to profound bilateral sensorineural hearing loss and severely deficient speech discrimination; or (2) post-lingual deafness in an adult. Hearing aid hardware is limited to one hearing aid per ear every three years. All expenses are subject to the deductible and apply to the out-of-pocket maximum. For the KPIC HAP, see page 35 “Emergency, Post-Stabilization, and Out-of-Area Urgent Care Received from Non-Network Providers – KPIC HAP” on page 130for criteria for cochlear implant evaluation (required).

How the HAP Works

Depending on where you live, you may choose Anthem Blue Cross or KPIC to be your administrator for the Health Account Plan (HAP). Anthem Blue Cross is the Claims Administrator on behalf of Anthem Blue Cross Life & Health Insurance Company (referred to as "Anthem" or "Anthem Blue Cross" in this document). Kaiser Permanente Insurance Company (KPIC) is its own Claims Administrator (referred to as "KPIC" in this document).

Important Information

For additional important information about the Anthem HAP and KPIC HAP, see the "Glossary" on page 174 and "Claims and Appeals Process" on page 180.

Network Providers

The HAP administered by Anthem Blue Cross (the "Anthem HAP") provides coverage through an Anthem Blue Cross preferred provider organization (PPO), a network of doctors, hospitals, laboratories and other providers who have agreed to provide services at negotiated rates. If you receive care from a NETWORK PROVIDER who charges more than the negotiated rate, you will be held harmless for those charges above the negotiated rate. Similarly, if a network provider has referred you to a NON-NETWORK PROVIDER, you will not be responsible for fees over the reasonable and customary charge.

The HAP administered by KPIC (the "KPIC HAP") provides coverage through an exclusive provider organization (EPO), a network of doctors, hospitals, laboratories and other providers who have agreed to provide services. Your share of the costs is based on KPIC's determined allowed amount, the Plan's schedule of benefits, and whether the services received are covered services. Unless otherwise stated in this summary, if you receive care from a NON-NETWORK PROVIDER, your services will not be covered under the Plan.

Inside California

The Anthem HAP uses the Anthem Blue Cross Prudent Buyer Plan PPO network. The KPIC HAP uses the Kaiser Permanente EPO network.

Outside of California, But Within the United States

If you're in the Anthem HAP, you can access benefits through the BlueCard Program, which enables members traveling or living outside their home state to access a broader network of doctors and hospitals at discounted rates through other Blue Cross/Blue Shield plans. While these PPO providers are available to you through the BlueCard Program, they do not contract directly with Anthem Blue Cross. Also available are traditional providers who might not participate in a BlueCard PPO network, but who have agreed to provide Anthem Blue Cross PPO members with health care services at a discounted rate. To locate BlueCard PPO providers, you may:

- call Anthem Blue Cross Member Services at 800-964-0530; or
- visit the Anthem Blue Cross website at www.anthem.com/ca/pge or www.anthem.com/ca.

Anthem members may go directly to any provider or specialist of your choice without PRE-AUTHORIZATION from a primary care PHYSICIAN (PCP).

KPIC members must receive all covered services from network providers inside the Kaiser Permanente California region, except in situations outlined in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care Received from Non-Network Providers – KPIC HAP" on page 130.

Non-Network Providers

Under the Anthem HAP, you may go to any United States non-network doctor or HOSPITAL at any time.

If you're in the Anthem HAP and receive care from a NON-NETWORK PROVIDER, you generally will be charged fees that are higher than the NEGOTIATED RATE charged by a NETWORK PROVIDER and will be responsible for the portion of those fees that are over the reasonable and customary limits. You may also be responsible for any ineligible expenses or even the entire bill. You should discuss this with your PHYSICIAN, as these amounts can be substantial.

If you're in the KPIC HAP, you have coverage for care received from a non-network provider only as outlined under "Emergency, Post-Stabilization, and Out-of-Area Urgent Care Received from Non-Network Providers – KPIC HAP" on page 130.

Please remember, Anthem and KPIC HAP members have a responsibility to work together with the physician(s) you select to ensure that all your medical needs are appropriately met. Anthem HAP members must notify the appropriate Medical Management Program when PRE-AUTHORIZATION is required. (See "Medical Management Programs" on page 133 for more information).

Deductibles

The ANNUAL DEDUCTIBLE is the amount you must pay before the plan starts paying benefits, subject to some exceptions. The annual deductible is the same for all HAP members, regardless of your claims administrator.

One Person	$1,000
Family	$2,000

For the Anthem HAP, charges for non-covered services, penalties for not obtaining PRE-AUTHORIZATION, and amounts over reasonable and customary do not apply toward the annual deductible.

For the KPIC HAP, charges for non-covered services, penalties for not obtaining pre-authorization for emergency post-stabilization care, and amounts in excess of the "allowance" — a dollar amount the Plan will pay for benefits for a service during a specified period of time — are your responsibility to pay and do not apply toward your deductible.

Plan Maximums

Out-of-Pocket Maximums

The Plan has an out-of-pocket maximum that limits the amounts you pay for covered services. The annual out-of-pocket maximum is the maximum amount you pay each calendar year for covered expenses, including deductibles and coinsurance.

Level of Coverage	Out-of-Pocket Maximum
One Person	$2,400
Family	$4,800

For the Anthem HAP, charges for non-covered services, penalties for not obtaining PRE-AUTHORIZATION, and amounts over reasonable and customary charges, and any other ineligible expenses do not apply toward the annual out-of-pocket maximum.

For the KPIC HAP, charges for non-covered services, penalties for not obtaining pre-authorization for emergency post-stabilization care, and amounts in excess of the "allowance" — a dollar amount the Plan will pay for benefits for a service during a specified period of time — are your responsibility to pay and do not apply toward your annual out-of-pocket maximum.

Lifetime Maximums

The Plan does not have an overall lifetime maximum benefit, but there is a lifetime maximum for INFERTILITY services:

Services or Supply*	Lifetime Maximum
Infertility Treatments	$7,000 (maximum does not coordinate with Prescription Drugs)

Coinsurance and Benefit Percentages

Coinsurance is the percentage of the covered cost you owe after paying the ANNUAL DEDUCTIBLE. For some services, such as additional primary care past your four free visits each year, you don't have to meet the annual deductible before coinsurance applies, but for most services the deductible applies. Coinsurance amounts are listed under the Summary of HAP Benefits.

For Anthem HAP members, ELIGIBLE EXPENSES will be reimbursed based on negotiated rates for NETWORK PROVIDERS and reasonable and customary charges for NON-NETWORK PROVIDERS, after you have met the annual deductible. If your non-network provider bills an amount above the reasonable and customary charges, you will be responsible for paying the difference along with your coinsurance. Network providers have agreed not to charge you more than the negotiated rate, so you will not be responsible for any amount in excess of the negotiated rate for covered health services when you use a network provider.

For KPIC HAP members, eligible expenses will be reimbursed based on the following:

- For services provided by KPIC, the charge shown in the KPIC HAP fee schedule.
- For services provided by approved network providers (other than KPIC HAP network providers) who contract with Kaiser Permanente, the amount that the provider has agreed to accept as payment in full under that contract.
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the charge shown in the KPIC HAP fee schedule.
- For all other services, the amounts that KPIC allows for those services.

Outpatient Hospital Services

The HAP provides coverage for outpatient HOSPITAL services including outpatient surgery, radiation therapy, chemotherapy and dialysis. For outpatient hospital care, including X-rays and lab tests, you pay 20% after the ANNUAL DEDUCTIBLE has been met.

Physician Office Visits

The first four visits to an in-network primary care PHYSICIAN (PCP) are fully covered (no deductible). You will pay 10% of the NEGOTIATED RATE for all subsequent visits. No ANNUAL DEDUCTIBLE applies for primary care visits. If you are an Anthem HAP member, you may go to a non-network PCP; however, you will be responsible for any charges that exceed the reasonable and customary (R&C) amount, and these amounts will not apply to your deductible or out-of-pocket maximum. KPIC HAP members will be covered for out-of-network primary care office visits only as described under "Emergency, Post-Stabilization, and Out-of-Area Urgent Care Received from Non-Network Providers – KPIC HAP" on page 130.

Visits to a specialist will be charged the specialty cost share of 20% after the annual deductible has been met. For Anthem HAP members, no referral from your PCP will be required in order for you to see your specialist. If you go to a non-network specialist, you pay 20% of R&C charges after your deductible (see "How Benefits Are Determined" on page 128). You will be responsible for any amounts above R&C and those amounts will not apply to either your deductible or out-of-pocket maximum.

For KPIC HAP members, your network primary care physician will refer you, as appropriate, to receive specialty care. Certain specialty procedures will be also be considered physician office visits (such as sleep studies). The annual deductible applies first, and then coinsurance benefits begin. If you go to a NON-NETWORK PROVIDER, services will be covered only for authorized referrals, emergencies, post stabilization, and out-of-area URGENT CARE. For details, see "Emergency, Post-Stabilization, and Out-of-Area Urgent Care Received from Non-Network Providers – KPIC HAP" on page 130.

How Benefits Are Determined

This section describes how Anthem Blue Cross and KPIC determine benefits under the HAP.

Reasonable and Customary (R&C) Charges – Anthem HAP

If you are in the Anthem HAP, reasonable and customary charges are those charges for covered services rendered by or on behalf of a non-network PHYSICIAN, for an amount not to exceed the allowed amount determined by Anthem Blue Cross.

A reasonable and customary charge is a charge which falls within the common range of fees billed by a majority of physicians for a procedure in a given geographic REGION. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

Covered Health Services

Covered health services are those health services, supplies or equipment provided for the purpose of preventing, diagnosing or treating a sickness, injury, covered medical condition, or its symptoms.

A covered health service is a MEDICALLY NECESSARY health care service or supply described under "What the HAP Covers" on page 142 as a covered health service and which is not excluded under "What the HAP Doesn't Cover" on page 151, such as experimental or investigational services or unproven services.

Covered health services must be provided:

- when the Plan is in effect;
- prior to the EFFECTIVE DATE of any of the individual termination conditions set forth in this Summary Plan Description; and
- only when the person who receives services is a covered person and meets all eligibility requirements specified in the Plan.

Decisions about whether to cover new technologies, procedures and treatments will be determined by Anthem Blue Cross or KPIC, as applicable.

Medically Necessary Services

Under the HAP, the fact that a PHYSICIAN, licensed professional or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it MEDICALLY NECESSARY, even though it is not specifically listed as an exclusion or limitation. The services or supplies must be ordered by the attending physician or licensed professional for the direct care and treatment of a covered illness, injury or condition. Services must be standard medical practice where received for the illness, injury or condition being treated and must be legal in the United States.

MEDICALLY NECESSARY services are those procedures, supplies, equipment or services that your Claims Administrator determines to be:

- appropriate and necessary for the diagnosis or treatment of the medical condition;
- provided for the diagnosis or direct care and treatment of the medical condition;
- within standards of good medical practice within the organized medical community;

- not primarily for your convenience, or for the convenience of your physician or another provider; and
- the most appropriate procedure, supply, equipment or service that can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
  - There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
  - Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
  - For HOSPITAL stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Special Situations — Emergency Care and Treatment Away From Home

Emergency Care

If you or a covered family member experiences a medical emergency, seeking prompt care should be the first priority. Under the HAP, emergency care is provided 24 hours a day, seven days a week, anywhere in the world.

A medical emergency is defined as a sudden and unforeseeable illness or injury of such a nature that failure to get immediate medical care could be life-threatening or cause serious harm to bodily function.

Examples of medical emergencies include:

- Apparent heart attack
- Severe shortness of breath
- Severe bleeding
- Apparent poisoning
- Obvious fractures
- Sudden vision loss
- Severe or multiple injuries
- Allergic reactions accompanied by swelling of the face and lips or wheezing in the chest
- Sudden loss of consciousness
- Convulsions

If you are in the Anthem HAP, you or your representative must notify Anthem Blue Cross within one working day of an emergency hospital admission or procedure, unless extraordinary circumstances prevent such notification within that time period.

If you are in the KPIC HAP and you have been admitted to a non-network HOSPITAL, your STAY will be covered if you or your representative notifies KPIC within 24 hours or as soon as possible after stabilization of your condition.

Receiving Care in Other Kaiser Permanente Regions

If you are enrolled in the KPIC HAP, you will probably receive most services in the SERVICE AREA of the Kaiser Permanente REGION where you live or work. If you are in the service area of another Kaiser Permanente region, you may receive services from NETWORK PROVIDERS in that region, though services that require a referral or PRE-AUTHORIZATION may differ among regions. For information about network providers or covered services in another region, please call Kaiser Permanente Customer Service (800-663-1771 for the Northern California Region or 800-533-1833 for the Southern California Region).

Emergency, Post-Stabilization, and Out-of-Area Urgent Care Received from Non-Network Providers – KPIC HAP

For KPIC HAP members, this section explains how to obtain covered emergency, post-stabilization, and out-of-area URGENT CARE from non-NETWORK PROVIDERS. The non-network provider care discussed in this section is not covered unless it meets both of the following requirements:

- this "Emergency, Post-Stabilization, and Out-of-Area Urgent Care Received from Non-Network Providers" section says that the care is covered; and
- the care would be covered if you received the care from a Network Provider.

You do not need to get PRE-AUTHORIZATION from KPIC to get emergency services or urgent care from non-network providers outside the KPIC HAP service area. However, you (or someone on your behalf) must get pre-authorization from KPIC for you to get covered post-stabilization care from non-network providers.

Emergency Services

If you have an emergency medical condition, call 911 (where available) or go to the nearest HOSPITAL emergency department. You do not need pre-authorization for emergency services. When you have an emergency medical condition, the Plan covers emergency services you receive from network providers or NON-NETWORK PROVIDERS anywhere in the world, as long as the services are covered under the Plan and subject to the same general exclusions and limitations, coordination of benefits, and reductions that would apply if you received these services from network providers.

Emergency services are available from hospital emergency departments 24 hours a day, seven days a week.

For ease and continuity of care, you are encouraged to go to a network hospital emergency department if you are inside the KPIC HAP service area, but only if it is reasonable to do so, considering your condition or symptoms. If you have been admitted to a non-network hospital, your STAY will be covered if Kaiser Permanente is notified within 24 hours or as soon as reasonably possible after stabilization of your condition.

Post-Stabilization Care

Post-stabilization care is defined as medically necessary services related to your emergency medical condition that you receive after your treating PHYSICIAN determines that your emergency medical condition is CLINICALLY STABLE. Post-stabilization care received from a non-network provider, including inpatient care at a non-network hospital, is covered only if Kaiser Permanente provides pre-authorization for the care.

To request pre-authorization to receive post-stabilization care from a non-network provider, you (or someone on your behalf) must call Kaiser Permanente toll free at the telephone number on your Kaiser Permanente ID card before you receive the care if it is reasonably possible to do so (otherwise, call as soon as reasonably possible). A Kaiser Permanente representative will then discuss your condition with the non-network provider. If Kaiser Permanente decides that you require post-stabilization care and that this care would be covered if you received it from a network provider, Kaiser Permanente will authorize your care from the non-network provider or arrange to have a network provider (or other designated provider) provide the care. If Kaiser Permanente decides to have a network hospital, network skilled nursing facility, or designated non-network provider provide your care, Kaiser Permanente may authorize special transportation services that are medically required to get you to the provider. If this occurs, then those special transportation services will be covered.

Be sure to ask the non-network provider to tell you what care (including any transportation) Kaiser Permanente has authorized, because non-authorized post-stabilization care or related transportation provided by non-network providers is not covered.

Sometimes extraordinary circumstances can delay your ability to call Kaiser Permanente to request authorization for post-stabilization care from a non-network provider (for example, if you are unconscious, or if you are a young child without a parent or guardian present). In these cases, you (or someone on your behalf) must call Kaiser Permanente as soon as reasonably possible.

Out-of-Area Urgent Care

If you need prompt medical care due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), the Plan covers MEDICALLY NECESSARY services that you receive from a non-network provider to prevent serious deterioration of your (or your unborn child's) health. In these cases, you or someone on your behalf (for example, if you are unconscious, or if you are a young child without a parent or guardian present) must call Kaiser Permanente as soon as reasonably possible to prevent serious deterioration of your (or your unborn child's) health if both of the following are true:

- You receive the services from non-network providers while you are temporarily outside the Kaiser Permanente service area
- You reasonably believe that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to the Kaiser Permanente service area.

Services Not Covered as Provider Emergency, Post-Stabilization, or Out-of-Area Urgent Care Received from Non-Network Providers

Services you receive outside the Kaiser Permanente service area that are not emergency services, post-stabilization care, or urgent care are not covered by the KPIC HAP, even if those services are related to your emergency medical condition.

Payment and Reimbursement

If you receive emergency services, post-stabilization care, or urgent care outside the KPIC HAP service area from a non-network provider, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill KPIC. To request payment or reimbursement, you must file a claim as described in the "Claims and Appeals Process" on page 180.

Cost Sharing

The cost sharing for emergency services, post-stabilization care, or urgent care that you receive from a non-network provider outside the KPIC HAP service area is the same as that for a network provider. Your required cost sharing will be subtracted from any payment made to you or the non-network provider.

Treatment Away From Home

While Working Away From Home

If you are in the Anthem HAP: If you have a work assignment outside of your home area — where there are no PPO NETWORK PROVIDERS — you will be covered at the same level of coinsurance as if you had used an in-network Anthem Blue Cross provider. However, any ELIGIBLE EXPENSES will be reimbursed based on reasonable and customary (R&C) levels, as determined by Anthem Blue Cross. You will be responsible for any amounts above R&C and those amounts will not apply to either your deductible or out-of-pocket maximum.

If you are in the KPIC HAP: If you have a work assignment outside of your home area — where there are no network providers — services will only be covered for authorized referrals, emergencies and out-of-area URGENT CARE. For details, see "Emergency, Post-Stabilization, and Out-of-Area Urgent Care Received from Non-Network Providers – KPIC HAP" on page 130.

Non-Emergency Care While Traveling Away From Home

For Anthem HAP members, if you are traveling in the United States, you may seek care from any licensed provider. If you are traveling out of the country, you may seek urgent or emergency care from any licensed provider. However, before leaving the U.S., you can call 800-810-BLUE (2583) and a BlueCard coordinator can provide you with a list of Blue Cross Association participating hospitals in several international cities. You may also find this information on Anthem's website at www.anthem.com/ca/pge. For inpatient care at a network BlueCard HOSPITAL, you pay only the applicable deductibles and coinsurance. The provider files the claim for you.

For inpatient care at a non-network hospital, you will need to pay the hospital at the time you receive services and then submit a claim for reimbursement. To locate a claim form, go to www.anthem.com/ca/pge, then under "Tools & Information," select "Forms." To receive reimbursement, submit your claim form to Anthem Blue Cross with a letter explaining that the claim was incurred while traveling outside the country, along with a receipt for services, translated in English, if possible, which includes the following:

- dates of service;
- procedure codes or description of services; and
- provider's name.

If you need treatment for a life-threatening emergency while traveling away from home, you should follow the steps under Emergency Care listed under Special Situations in this section.

For KPIC HAP members, if you are traveling outside a Kaiser Permanente REGION, services will only be covered for authorized referrals, emergencies and out-of-area urgent care. For details, see "Emergency, Post-Stabilization, and Out-of-Area Urgent Care Received from Non-Network Providers – KPIC HAP" on page 130.

Dependent Children Living Away From Home

Dependent children covered under the HAP who are residing away from home (for example, while attending school in the United States) will receive benefits in accordance with the provisions of the HAP.

If you are in the Anthem HAP: If your enrolled dependents are outside of California, they may access benefits with the BlueCard program, which enables members traveling or living outside their home state to access a broader network of doctors and hospitals at discounted rates through other Blue Cross/Blue Shield plans. To locate BlueCard providers, call toll-free 800-810- 2583. This number is also printed on the back of your ID card for handy reference.

If you are in the KPIC HAP, to obtain information about network providers or covered services in another region, please call customer service for that region. Please note that processes for authorized referral and PRE-AUTHORIZATION may differ among regions.

Medical Management Programs

The Medical Management Programs for the Health Account Plan (HAP) depend on whether Anthem Blue Cross or KPIC is your administrator. There are some differences in how the Medical Management Programs are applied between the two administrators. See the section pertaining to your administrator for more information.

Not Applicable for Secondary Coverage

Medical management requirements described in this section do not apply when coverage under this Plan is secondary to another plan providing benefits for you or your dependents.

Medical Management – Anthem Blue Cross

The Medical Management Programs at Anthem Blue Cross consist of the following:

- Utilization Review Program (pre-service review, care coordination review, retrospective review); and
- Personal Case Management.

Medical management programs are designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out-of-pocket expenses. Benefits are provided only for MEDICALLY NECESSARY and appropriate services.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and payment of benefits is subject to all the terms and requirements of the Plan. If benefits are denied or reduced as a result of these programs, you may apply for consideration under the claims and appeals process.

Failure to obtain authorization for specified services will result in a $300 penalty.

Utilization Review Program

The Anthem HAP Utilization Review Program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your PHYSICIAN are advised if it has been determined that services can be safely provided in an outpatient setting or if an inpatient STAY is recommended. Services that are MEDICALLY NECESSARY and appropriate are certified by Anthem Blue Cross and monitored so that you know when it is no longer medically necessary and appropriate to continue those services.

Participating providers will initiate the review on your behalf. A non-participating provider may or may not initiate the review for you. In both cases, it is your responsibility to initiate the process and ask your physician to request pre-service review.

Utilization Review Requirements

Utilization reviews are required by the Anthem HAP for:

- Inpatient HOSPITAL admission stays. (A $300 penalty applies for not obtaining PRE-AUTHORIZATION.)
- Exceptions: Utilization review is not required for inpatient hospital stays for the following services:
  - Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and
  - Mastectomy and lymph node dissection.
- AMBULATORY SURGICAL CENTER and outpatient surgeries.
- Home Infusion.

Review Stages

There are three stages of utilization review:

- **Pre-service review** determines the medical necessity and appropriateness of scheduled, non-emergency inpatient hospital admissions.
- **Concurrent review** determines whether services are medically necessary and appropriate when pre-service review is not required or when Anthem Blue Cross is notified while service is ongoing, for example, after an emergency admission to the hospital.
- **Retrospective review** is performed to review services that have already been provided.
  - This applies in cases when pre-authorization, pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

Effect on Benefits

In order for the full benefits of the Plan to be payable, the following criteria must be met:

- The appropriate utilization reviews must be performed in accordance with the Plan.
- When pre-service review is not performed as required for an anticipated inpatient hospital admission, a $300 penalty will be applied. The services must be medically necessary and appropriate.

  Inpatient hospital benefits will be provided only when an inpatient stay is medically necessary and appropriate. If you proceed to receive any services that have been determined to be not medically necessary or not appropriate at any stage of the utilization review process, benefits will not be provided for those services.
- Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment.

  If that review results in the determination that part or all of the services were not medically necessary or not appropriate, benefits will not be paid for those services. Remaining benefits will be subject to previously noted reductions that apply when the required reviews are not obtained.

How to Obtain Utilization Reviews

Remember, it is always your responsibility to confirm that the review has been performed. If the review is not performed, your benefits will be reduced as described in "Effect on Benefits."

Pre-Service Reviews

Penalties will result for failure to obtain pre-service review before receiving scheduled services, as follows:

- For all scheduled services that are subject to utilization review, you or your physician must initiate the pre-service review at least five working days prior to when you are scheduled to receive services.
- Physicians who are network providers will initiate the review on your behalf. A non-network provider may initiate the review for you, or you may call Anthem Blue Cross directly. The toll-free number for pre-authorization and pre-service review is 800-274-7767. This number is printed on your ID card.
- If you obtain certification for a service but the certified service is not rendered within 60 days of obtaining the certification, or if the nature of the service changes, a new pre-service review must be obtained.
- Anthem Blue Cross will certify services that are medically necessary and appropriate. For inpatient hospital stays, Anthem Blue Cross will, if appropriate, certify a specific length of stay for approved services. You, your physician and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

- If pre-service review was not performed, you, your physician or the provider of the service must contact Anthem Blue Cross for concurrent review. For an emergency admission or procedure, Anthem Blue Cross must be notified within one working day of the admission or procedure, unless extraordinary circumstances prevent such notification within that time period.

  - In determining "extraordinary circumstances," Anthem Blue Cross may take into account whether or not your condition was severe enough to prevent you from notifying them, or whether or not a member of your family was available to notify Anthem Blue Cross for you. You may have to prove that such "extraordinary circumstances" were present at the time of the emergency.

- When NETWORK PROVIDERs have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a NON-NETWORK PROVIDER to call the toll-free number printed on your identification card or you may call directly. The toll-free number for pre-authorization and pre-service review is 800-274-7767. This number is printed on your ID card.

When it is determined that the service is medically necessary and appropriate, Anthem Blue Cross will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. Anthem Blue Cross will also determine the medically appropriate setting.

If it is determined that the service is not medically necessary or not appropriate, your physician will be notified by telephone no later than 24 hours following Anthem Blue Cross' decision. Anthem Blue Cross will send written notice to you and your physician within two business days following the decision. However, care will not be discontinued until your physician has been notified and a plan of care that is appropriate for your needs has been agreed upon.

Retrospective Reviews

- Retrospective review is performed when Anthem Blue Cross is not notified of the service you received, and is therefore unable to perform the appropriate review prior to your discharge from the hospital or completion of outpatient treatment. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified.
- Retrospective review may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or concurrent review was performed.
- Such services which have been retrospectively determined to be not medically necessary or not appropriate will be retroactively denied certification.

Authorization Program

The Anthem HAP Authorization Program provides PRE-AUTHORIZATION for certain "special services." When your PHYSICIAN is a NETWORK PROVIDER, it is your physician's responsibility to obtain pre-authorization before you receive any service subject to the Authorization Program. When your physician is a non-network provider, it is your responsibility to obtain pre-authorization before you receive any service subject to the pre-authorization process. Call Anthem Blue Cross' pre-authorization and pre-service review toll-free number at 800-274-7767, which is printed on your ID card.

If you receive any such service and do not follow the procedures outlined in this section, your benefits will be reduced as shown under "Effect on Benefits" under "Medical Management – Anthem Blue Cross" on page 133.

Services Requiring Authorization

Special Services

Pre-authorization is required to obtain benefits for:

- Organ and tissue transplants; see "Organ and Tissue Transplants" on page 145.
- Transplant travel expense benefits; see "Transportation and Lodging" on page 146.
- Home health care; HOSPICE, or home hospice care; see "Home Health Care and Hospice Care" on page 143.
- Admissions to a SKILLED NURSING FACILITY; see "Skilled Nursing Facility" on page 147.
- Purchase or rental of durable medical equipment for which the total price is equal to or greater than $1,000 (a $300 penalty is assessed if pre-authorization is not obtained).

Effect on Benefits

Special Services

- A $300 penalty is assessed if pre-authorization is not obtained for the following special services: skilled nursing facility admissions; home health care; hospice or home hospice care; or the purchase or cumulative rental of durable medical equipment equal to or over $1,000.
- No coverage will be provided for transplants or transplant travel expenses that have not been pre-authorized.

When Authorization Will Be Provided

- The services are authorized as medically necessary before services are received.

Special Services

Organ and Tissue Transplants

Authorizations for organ and tissue transplants will be provided as follows:

- For bone, skin or cornea transplants, both of the following criteria must be met:
  - The services are medically necessary and appropriate; and
  - The physicians on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
- For transplantation of liver, heart, heart-lung, lung, kidney, pancreas, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures, both of the following criteria must be met:
  - The services are medically necessary and appropriate; and
  - The providers of related pre-operative and post-operative services are approved.

Note: Organ and tissue transplants are only covered at a Center of Medical Excellence (CME) or a facility approved by Anthem Blue Cross for kidney and cornea transplants. See "Organ and Tissue Transplants" on page 145 for more details.

Transplant Travel Expense Benefits

- Authorizations for transplant travel expense benefits will be provided for the recipient and one companion (up to two companions if the transplant recipient is a child) only if all of the following criteria are met:
  - The procedure is for transplantation of liver, heart, heart-lung, lung, kidney-pancreas, kidney, cornea, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures, and authorized by Anthem Blue Cross;
  - The organ transplant must be performed at a specific Center of Medical Excellence (CME) or at a pre-authorized participating kidney or cornea transplant facility; and
  - The specific CME or other qualifying facility is 75 miles or more from the recipient's home.

Home Health Care

See "Home Health Care and Hospice Care" on page 143.

- Authorizations for home health care services will be provided only if all of the following criteria are met:
  - The services are medically necessary and appropriate and can be safely provided in the beneficiary's home, as certified by the attending physician;
  - The attending physician manages and directs the beneficiary's medical care at home; and
  - The attending physician must establish a definitive treatment plan which must be consistent with the beneficiary's medical needs and must list the services to be provided by the home health agency.

Skilled Nursing Facility

See "Skilled Nursing Facility" on page 147.

- Anthem Blue Cross will authorize inpatient services provided in a skilled nursing facility only if all of the following criteria are met:
  - You require daily skilled nursing or rehabilitation, as certified by the attending physician;
  - You were an inpatient in a hospital for at least three consecutive days, and are to be admitted to the skilled nursing facility within 30 days of your discharge from the hospital
  - You will be treated for the same condition for which you were treated in the hospital; and
  - The care that you will receive is medically necessary and is not custodial, as determined by Anthem Blue Cross.

Durable Medical Equipment

- Pre-authorization is required for the purchase or rental of durable medical equipment for which the total price is $1,000 or more.

How to Obtain an Authorization

For Special Services

To obtain pre-authorization, you or your physician must call the Anthem Blue Cross pre-authorization and pre-service review toll-free number at 800-274-7767 prior to receiving services.

Medical Necessity Review Process

Anthem Blue Cross will work with you and your health care providers to determine what is or is not medically necessary and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, Anthem Blue Cross is committed to ensuring that reviews are performed in a timely and professional manner.

The review process follows the same procedures and timing as the benefit claim process. See the "Claims and Appeals Process" on page 180.

Personal Case Management

The Personal Case Management Program enables you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. Anthem Blue Cross, through a case manager, may recommend an alternative plan of treatment, which may include services not typically covered under the Plan. Anthem Blue Cross does not have an obligation to provide personal case management. These services are provided at the sole and absolute discretion of Anthem Blue Cross. Examples of conditions that may fall under Personal Case Management include:

- Burns
- Cerebral Vascular Accident (CVA)
- Migraine
- Sickle Cell Disease
- Trauma

These Are Examples

These conditions or diagnoses are not a guarantee of acceptance into the Personal Case Management Program. Cases are reviewed and criteria applied to determine possible enrollment, and enrollment is contingent upon member consent.

How Personal Case Management Works

You may be identified for possible personal case management through the Plan's utilization review procedures, by the attending physician or hospital staff, or through Anthem Blue Cross' claims reports. You or your family may also call Anthem Blue Cross and request personal case management.

Benefits for personal case management will be considered only when all of the following criteria are met:

- You require extensive long-term treatment;
- Anthem Blue Cross anticipates that such treatment utilizing services or supplies covered under the Plan will result in considerable cost;
- A cost-benefit analysis determines that the benefits payable under the Plan for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under the Plan while maintaining the same standards of care; and
- You (or your legal guardian) and your physician agree, in a letter of agreement, with Anthem Blue Cross' recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan

If Anthem Blue Cross determines that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits typically not covered under the Plan. A case manager will review the medical records and discuss your treatment with the attending physician, you, and your family.

Anthem Blue Cross makes treatment recommendations only; you and your physician make the decisions regarding treatment. The Plan will not compromise your freedom to make such decisions.

The Effect Personal Case Management Has on Benefits

- Any alternative benefits are accumulated toward the corresponding benefit maximums.
- Benefits are provided for an alternative treatment plan on a case-by-case basis only. Anthem Blue Cross has absolute discretion in deciding whether or not to authorize services in lieu of benefits for any covered person, which alternatives may be offered and the terms of the offer.
- The pre-authorization of services in lieu of benefits in a particular case in no way commits the Plan to do so in another case or for any other covered person.
- The Personal Case Management Program does not prevent Anthem Blue Cross from strictly applying the expressed benefits, exclusions and limitations of the Plan at any other time or for any other covered person.

Third Parties

Anthem Blue Cross and KPIC reserve the right to use the services of one or more third parties in executing the performance of the services under the HAP. No other assignment of any rights or delegation of any duties by either party is valid without the prior written consent of the other party.

Medical Management Programs – KPIC

The Medical Management Programs at KPIC — referred to as "Integrated Care Management"— consists of the following:

- Utilization Review Program; and
- Pre-Authorization and Referrals.

Benefits are provided only for MEDICALLY NECESSARY and appropriate services. Medical management programs are designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out-of-pocket expenses.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and payment of benefits is subject to all the terms and requirements of the Plan. If benefits are denied or reduced as a result of these programs, you may apply for consideration under the claims and appeals process.

- To ensure cost effective care is provided under the Plan, an alternative plan of treatment may be provided to members at a lower overall cost while maintaining the same standards of care. Alternative plan of treatments (e.g., home dialysis, home sleep study or other special services) may not have member cost share.

Utilization Review Program

The KPIC HAP Utilization Review Program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your PHYSICIAN are advised if it has been determined that services can be safely provided in an outpatient setting or if an inpatient STAY is recommended. Services that are MEDICALLY NECESSARY and appropriate are certified by KPIC and monitored so that you know when it is no longer medically necessary and appropriate to continue those services.

When services are performed by NETWORK PROVIDERS, it is your provider's responsibility to start the utilization review process. For emergency and URGENT CARE from non-network providers, it is your responsibility to see that your physician starts the utilization review process before scheduling you for any service subject to the Utilization Review Program. If you receive any such service and do not follow the procedures set forth in this section, your benefits may be reduced.

Review Stages

The KPIC HAP has several stages of utilization review:

- **Precertification review** includes eligibility verification and confirmation, determination of covered services and communication with the network provider and/or you in advance of the procedure, service or supply. Utilization review includes pre-service discharge planning or need for specialized programs such as case management, if applicable.
- **Concurrent review** monitors on an ongoing basis your health care services in the inpatient setting in order to assess your clinical condition and the ongoing delivery of medical services and treatments to determine Covered Services. Concurrent review includes patient management that takes place at a network facility during inpatient care or during an ongoing outpatient course of treatment.
- **Retrospective review** reviews services that have already been provided. When performed, this applies to initial certification after the service has been provided or when you are no longer an inpatient or receiving the service in order to evaluate and audit medical documentation subsequent to services being provided.
- **Discharge planning** assists you as your medical condition changes and you transition from the inpatient setting. Discharge planning may be initiated at any stage of the Patient Management process. Assessment of potential discharge planning needs begins at the time of notification, and coordination of discharge plans commences upon identification of post-discharge needs during PRE-AUTHORIZATION or concurrent review. This program will include evaluation of alternate care settings and identification of care needed after discharge. The goal is to provide continuing quality of care and to avoid delay in discharge due to lack of outpatient support.
- **Case management** manages ongoing care if your medical condition requires the assessment, planning, facilitation and education about options to meet your needs to promote quality, cost-effective outcomes.
- **Disease management/health education** features disease management programs that focus on improving the management of care for those with certain medical diagnoses or risk factors. The disease management programs shall include identification, stratification and intervention for those who can benefit from improved care. Kaiser Permanente may also administer health education and wellness programs with a focus on outreach to encourage you to receive preventive care and participate in health education and other similar programs.
- **The Health Care Assistance line** provides you with toll-free access to registered nurses experienced in providing information on a variety of health topics. KPIC's advice nurses can help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern, tell you what to do if a network provider is closed, or advise you about what to do next, including making a same-day appointment for you if it's medically appropriate. To contact an advice nurse, call the number for your REGION (866-454-8855 for the Northern California Region or 888-576-6225 for the Southern California Region).

Pre-Authorization and Referrals

Pre-authorization is medically necessary approval obtained in advance which is required for certain services to be covered services under the Health Account Plan (HAP). Pre-authorization is not a guarantee of payment and will not result in payment for services that do not meet the conditions for payment by the HAP as determined by the Claims Administrator. Your KPIC physician will request pre-authorization when it is required.

You do not need a referral or pre-authorization to receive care from any of the following:

- Your personal network physician;
- Generalists in internal medicine, pediatrics, and family practice;
- Specialists in optometry, psychiatry, substance abuse; or
- Network providers who specialize in obstetrics or gynecology.

Services that require pre-authorization include:

- All inpatient and outpatient facility services (excluding emergencies)
- Office-based rehabilitation: Occupational, Speech, and Physical therapies.
- All services provided by non-network providers, and all services provided outside a KP facility: If your network physician decides that you require covered services not available from network providers, he or she will recommend to the Medical Group that you be referred to a non-network provider inside or outside the KPIC HAP SERVICE AREA. The appropriate Medical Group designee will authorize the services if he or she determines that they are medically necessary and are not available from a network provider. Referrals to non-network physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your network physician what services have been authorized. In certain cases, such as covered POST-STABILIZATION CARE, you may need to request pre-authorization before receiving services.
- Drugs and Durable Medical Equipment not contained on the KP formula: If your network physician prescribes a DME item, he or she will submit a written referral to the HOSPITAL's DME coordinator, who will authorize the DME item if he or she determines that your DME coverage includes the item and that the item is listed on the DME formulary for your condition. If the item doesn't appear to meet the DME formulary guidelines, then the DME coordinator will contact the network physician for additional information. If the DME request still doesn't appear to meet the DME formulary guidelines, it will be submitted to the Medical Group's designee physician, who will authorize the item if he or she determines that it is medically necessary.
- Ostomy and urological supplies: If your network physician prescribes ostomy or urological supplies, he or she will submit a written referral to the hospital's designated coordinator, who will authorize the item if he or she determines that it is covered and the item is listed on the soft goods formulary for your condition. If the item doesn't appear to meet the soft goods formulary guidelines, then the coordinator will contact the network physician for additional information. If the request still doesn't appear to meet the soft goods formulary guidelines, it will be submitted to the Medical Group's designee physician, who will authorize the item if he or she determines that it is medically necessary.
- Transplants: If your network physician makes a written referral for a transplant, the Medical Group's Regional transplant advisory committee or board (if one exists) will authorize the services if it determines that they are medically necessary. In cases where no transplant committee or board exists, the Medical Group will refer you to physician(s) at a transplant center, and the Medical Group will authorize the services if the transplant center's physician(s) determine that the services are medically necessary.

Referrals

You are required to obtain a referral from your network physician prior to receiving specialty care services under the Plan. If you receive specialty care services for which you did not obtain a referral, you will be responsible for all the charges associated with those services.

Self Referrals

You do not need a referral or pre-authorization to receive care from any of the following:

- Your personal network physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, psychiatry, substance abuse
- Obstetrical or gynecological care from a network provider who specializes in obstetrics or gynecology

Although a referral or pre-authorization is not required to receive care from these providers, the provider may have to get pre-authorization for certain services.

Second Opinions

Upon request and subject to payment of any applicable coinsurance, you may obtain a second opinion from:

- A network physician about any proposed Covered Services, or
- A non-network provider with Prior Authorization.

What the HAP Covers

This section lists covered medical services and supplies that are frequently used. If you have any questions on whether or not a specific service or supply is covered by the Plan, contact Anthem Blue Cross Member Services at 800-964-0530 or Kaiser Permanente Customer Service (800-663-1771 for the Northern California REGION or 800-533-1833 for the Southern California Region).

For ease of reviewing, HAP covered services are listed in alphabetical order, with the exception of "Other Covered Medical Services and Supplies" on page 148, which is listed last.

Acupuncture

For acupuncture care, you pay 10%, subject to deductible, for the first five visits to an acupuncture provider. You pay 20% for all subsequent visits. (For purposes of determining coinsurance rates, tallying of the first five visits does not begin until the deductible has been met.) There is no yearly limit on visits if the care is deemed MEDICALLY NECESSARY. If you are in the Anthem HAP, after the 5th visit you must receive preauthorization prior to obtaining additional services, and the services must be deemed medically necessary. KPIC members must use network acupuncture providers to obtain coverage. Anthem HAP members can locate network acupuncture providers by calling Anthem Blue Cross directly or visiting its website.

KPIC HAP members can locate network acupuncture providers by calling American Specialty Health Plans of California at 800-678-9133 or visiting its website at www.ashcompanies.com.

Ambulance Services

- You pay 20% for the following ambulance services, subject to the deductible.

Emergency Only

Emergency ambulance transportation, provided by a licensed ambulance service, to the nearest HOSPITAL where emergency health services can be performed.

Non-Emergency

- Transportation by professional ambulance, other than air ambulance, to and from a medical facility when MEDICALLY NECESSARY.
- Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment when medically necessary.

For Anthem HAP members, ambulance transport from a non-network hospital to a network hospital is covered at 80% after deductible. For KPIC HAP members, ambulance transport from a non-network hospital to a network hospital is fully covered (no deductible).

Chiropractic Care

For chiropractic care, you pay 10%, subject to deductible, for the first five visits to a chiropractor. You pay 20% for all subsequent visits. (For purposes of determining coinsurance rates, tallying of the first five visits does not begin until the deductible has been met.) There is no yearly limit on visits if the care is deemed MEDICALLY NECESSARY. KPIC members must use network providers to obtain coverage.

If you are in Anthem HAP, after the 5th visit you must receive PRE-AUTHORIZATION before obtaining additional services, and the services must be deemed medically necessary. You can locate network chiropractic providers by calling Anthem Blue Cross directly or visiting its website.

KPIC HAP members can locate network chiropractic providers by calling American Specialty Health Plans of California at 800-678-9133 or visiting its website at www.ashcompanies.com.

Home Health Care and Hospice Care

For home health care, you pay 20%, subject to deductible. HOSPICE care under HAP is fully covered (no deductible). Home health care will not be covered while the covered person receives hospice care.

For Anthem HAP members, when your doctor recommends either home health or hospice care, you must call Anthem Blue Cross at 800-274-7767 to obtain PRE-AUTHORIZATION. A penalty of $300 applies if no pre-authorization is obtained. For KPIC HAP members, your doctor will obtain pre-authorization at the point of service.

The HAP will cover the services of an approved home health care agency or hospice agency, provided the services are MEDICALLY NECESSARY covered health services, not custodial in nature, and ordered by your attending PHYSICIAN (whether network or non-network). For the Anthem HAP, these services must be rendered under a written treatment plan approved by Anthem Blue Cross.

The HAP does not cover custodial care, which is defined as care provided primarily to assist an individual in meeting the activities of daily living including, but not limited to, walking, bathing, dressing, eating, preparation of special diets, changing catheters, and supervision over self-administration of medications not requiring constant attention of trained medical personnel. It is care that can be taught to a lay person who does not have any professional qualifications, skills or training.

Full-time nursing care in the home and homemaker services and supplies (including meals delivered to your home) are also not covered.

Services in Your Home

For services in your home, you pay 20%, subject to deductible, depending upon the type of provider or service rendered. The Plan covers the following NETWORK PROVIDER services when rendered in the patient's home, provided that the services are MEDICALLY NECESSARY covered health services and are not considered custodial care, as determined by Anthem Blue Cross or KPIC:

- Nursing services provided by a registered nurse (R.N.), or a licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.) when under the supervision of an R.N.
- Services of a home health aide.
- Physical, occupational, speech or respiratory therapy and supplies; medical social services; and covered nutritional counseling.
- For a patient formally admitted to a network hospice program: homemaking services; counseling for the patient and family members; up to three days of respite care during a six-month period; and bereavement counseling by a certified social worker who is an employee of the hospice, for up to 12 months after the patient's death. Bereavement counseling benefits are limited to $25 per visit, four visits per family.

For Anthem HAP members, one visit by a home health aide equals four hours or less.

For KPIC HAP members, for any visit by a nurse, medical social worker, or physical, occupational, or speech therapist that lasts longer than two hours, each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four hours counts as a separate visit.

Hospice Facility

Fully covered (no deductible). MEDICALLY NECESSARY covered health services in a HOSPICE facility are covered when a patient in the latter stages of a terminal illness is formally admitted to an inpatient hospice program and the appropriate Medical Management Program has approved the admission. For KPIC HAP members, services must be received at a network facility.

The following inpatient hospice services are covered:

- Bed, board and general nursing care.
- Medical care provided by other professional providers employed by the facility.

- Hospice facility services and supplies.
- Homemaking services.
- Up to three days of respite care during a six-month period.
- Family counseling related to the patient's illness.
- Bereavement counseling by a certified social worker who is an employee of the hospice, for up to 12 months after the patient's death. Benefits are limited to $25 per visit, four visits per family.

For KPIC HAP members, all services must be provided by a NETWORK PROVIDER.

Eligibility for hospice benefits begins on the date on which the patient's PHYSICIAN certifies that the patient has a life expectancy of 12 months or less.

The Plan does not cover homemaking services, except as specifically provided above. Food or home-delivered meals and services by volunteers who do not regularly charge for their services are not covered.

Coverage of physician, HOSPITAL, ambulance and dialysis services, purchase or rental of durable medical equipment, medical supplies, drugs and medicines is provided as described elsewhere in this Handbook.

Hospital Care — Inpatient

You pay 20% for inpatient HOSPITAL care after meeting the ANNUAL DEDUCTIBLE. For KPIC HAP members, services must be received at a network facility. For Anthem HAP members, pre-authorization is required for non-emergency care; a $300 penalty applies if pre-authorization is not obtained.

Covered inpatient hospital services include:

- Room and board in semi-private accommodations; private room if a MEDICALLY NECESSARY covered health service (as determined by standards set by Anthem Blue Cross or KPIC — see "Covered Health Services" under "How Benefits Are Determined" on page 128.
- SPECIAL CARE UNITS.
- Medical and surgical supplies.
- General private duty nursing care.
- Use of operating and special treatment rooms.
- Anesthesia and its administration by a salaried hospital employee.
- Administration of blood and blood plasma, including the cost of unreplaced blood, blood products and blood processing.
- Hospital ancillary services, including laboratory, cardiology, pathology, radiology and any professional components for such services.
- Routine nursery care for a newborn if the child is enrolled in the HAP.
- Drugs, medicines and oxygen supplied by and used in the hospital.
- Pre-admission testing performed within seven days before hospital admission or outpatient surgery.
- Radiation therapy, chemotherapy, physical therapy, respiratory therapy, and dialysis treatment.
- Short-term speech therapy for correction of speech impairments resulting from illness, injury, surgery, or previous therapeutic processes. Speech therapy due to functional nervous disorders is not covered.
- Physical therapy when furnished by the hospital as a regular service.
- Occupational therapy when furnished by the hospital in conjunction with physical therapy treatments.
- Dental care when a hospital admission is required for dental surgery or extraction of teeth, general anesthesia is required, and a PHYSICIAN certifies that the hospitalization is medically necessary. Any other service related to the dental procedure, such as the dentist's services, is not covered.

Hospital Care — Outpatient

You pay 20% for outpatient HOSPITAL care after meeting the ANNUAL DEDUCTIBLE.

Covered outpatient hospital services include:

- Outpatient surgical services. This includes MEDICALLY NECESSARY covered health services rendered in a freestanding AMBULATORY SURGICAL CENTER, a short-STAY surgical unit or an outpatient department of a hospital. For KPIC HAP members, services must be received at a network facility.
- Emergency hospital outpatient services for the first visit for emergency care and treatment of a sudden and unforeseeable illness or injury which, if not immediately diagnosed and treated, could be life-threatening or cause serious harm to bodily function.
- Medically necessary outpatient covered health services for radiation therapy, chemotherapy and hemodialysis treatment. For KPIC HAP members, services must be received at a network facility.
- Home dialysis: Covered at 80% after deductible for Anthem HAP members. Fully covered (no deductible) for KPIC HAP members.

Organ and Tissue Transplants

You pay 20%, subject to deductible, for organ and tissue transplants. PRE-AUTHORIZATION is required for all transplant services for benefits to be provided. Services must be provided by a NETWORK PROVIDER; no coverage is available out-of-network.

Benefits are available for the following organ and tissue transplants when the transplant is ordered by a PHYSICIAN, meets the definition of a covered health service and is not an unproven, experimental, or investigational service, as described under "What the HAP Covers" on page 142.

- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a covered health service.
- Heart transplants
- Heart/lung transplants
- Lung transplants
- Liver transplants
- Kidney transplants
- Kidney/pancreas transplants
- Liver/small bowel transplants
- Pancreas transplants
- Small bowel transplants
- Cornea transplants

Organ or tissue transplants or multiple organ transplants, other than those listed in this section, are currently excluded from coverage.

Bone Marrow Donor Search

PRE-AUTHORIZATION is required for bone marrow donor search services. You pay 20% for these services, subject to deductible, when you use NETWORK PROVIDERS. This search is only necessary when a family donor is not found. The maximum benefit per search is $30,000. Bone marrow donor search services are not covered out of network.

How to Obtain Authorization

PRE-AUTHORIZATION is required for all transplant services:

- For Anthem HAP members, you must call the Pre-Authorization and Pre-Service toll-free number at 800-274-7767 as soon as the possibility of a transplant arises. The Authorization Program will arrange for a pre-transplantation evaluation to be performed at a Center for Medical Excellence transplant facility. The Authorization Program also can discuss your benefit options and any special transplant guidelines.
- For KPIC HAP members, the medical group must have determined that you meet medical criteria for patients needing transplants. The medical group then provides a written referral to an approved transplant facility. The facility may be located outside the SERVICE AREA. Transplants are covered only at a facility approved by the medical group, even if another facility within the service area could perform the transplant. If you have questions, speak to your network PHYSICIAN or call 1-800-663-1771 for the Northern REGION or 1-800-533-1833 for the Southern Region.

Transportation and Lodging

The Authorization Program will assist the patient and family with travel and lodging arrangements associated with transplant procedures. Expenses for travel and lodging for the transplant recipient and companion(s) are based on IRS guidelines and are as follows:

- Transplant travel expense for a pre-authorized, specified transplant, including for purposes of evaluation prior to the transplant and post-discharge follow-up: expenses for recipient and companion transportation, such as airfare, train, and bus fares; hotel and apartment rentals; gas, parking, tolls and car rentals; and taxes on covered expenses.
- If the patient is a covered dependent minor child, the transportation expenses of up to two companions will be covered.
- There is a per-transplant maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures, per IRS regulations.

Inpatient Prescription Drugs

Prescription drugs you receive while you are hospitalized, or “inpatient” drugs, are covered at the 20% inpatient coinsurance level.

Professional Services

The following professional services are covered, if received from a NETWORK PROVIDER and deemed to be MEDICALLY NECESSARY covered health services as determined by Anthem Blue Cross or KPIC:

- Services of a PHYSICIAN, surgeon or assistant surgeon
- Services of an anesthetist or anesthesiologist in connection with surgery
- Services of a consulting physician when requested by your doctor
- Constant care services rendered by a physician when you are in critical condition
- Physician visits to a HOSPITAL or SKILLED NURSING FACILITY during a covered inpatient confinement
- Visits to your doctor’s office or physician house calls for treatment of illness, disease or injury (no charge for first four visits to a primary care physician (PCP))
- Well-baby care up to age two (no charge)
- Radiation therapy

- Outpatient diagnostic X-rays and lab exams, including routine or diagnostic Pap smears and mammograms (no charge for X-rays and lab work coded as preventive care)
- Injections, inoculations and immunizations (no charge for immunizations)
- Physician services in the outpatient department of a hospital, ambulatory surgical facility or short-STAY surgical unit
- Services of a licensed physical therapist for a covered inpatient hospital or skilled nursing facility confinement.

Diagnostic Screenings Aren't Free

Your medical plan administrator will determine which screenings are preventive (free) and which screenings are diagnostic (not free). For example, preventive mammograms are free but mammograms coded as "diagnostic" are not free. If your doctor sees something in a preventive mammogram and orders follow-up mammograms, those follow-up mammograms will be coded as diagnostic and will not be free — even if you're getting them in subsequent years after your free preventive mammogram.

Psychiatric Care and Substance Abuse Treatment

For Anthem HAP members, only MEDICALLY NECESSARY detoxification that is considered to be medical care is covered by the medical provisions administered by Anthem Blue Cross. Psychiatric care and substance abuse treatment are covered under the mental health and substance abuse provisions of the Plan, but are administered by ValueOptions.

For KPIC HAP members, all mental health and substance abuse treatment benefits are administered by KPIC with the following exceptions:

- Alcohol/substance abuse treatment and detoxification-inpatient—institutional services: Benefits are administered by ValueOptions.
- Alcohol/substance abuse treatment inpatient and residential treatment center: Benefits are administered solely by ValueOptions.
- Applied Behavioral Analysis (ABA): Benefits are administered by either ValueOptions or KPIC (member's choice).

For more details including coinsurance amount for mental health and substance abuse treatment, see "Mental Health and Substance Abuse Coverage" on page 155.

Skilled Nursing Facility

You pay 20% of the NEGOTIATED RATE, subject to deductible, for SKILLED NURSING FACILITY services when you use an Anthem Blue Cross PPO or Kaiser Permanente NETWORK PROVIDER. PRE-AUTHORIZATION is required. For Anthem HAP members, a penalty of $300 applies if no pre-authorization is obtained.

In addition, Anthem HAP members who use out-of-network providers will be responsible for any charges above the reasonable and customary (R&C) amounts. Kaiser HAP members must use network provider to obtain coverage.

For Anthem HAP members, either you or your doctor must contact Anthem Blue Cross for pre-authorization (see "Medical Management Programs" on page 133) and meet all the stated criteria for coverage. For KPIC HAP members, your network provider will request pre-authorization.

The services provided must be MEDICALLY NECESSARY covered health services (and not considered custodial care) so as to require confinement in a skilled nursing facility, as determined by Anthem Blue Cross or KPIC. (Custodial care is defined as care provided primarily to assist an individual in meeting the activities of daily living including, but not limited to, walking, bathing, dressing, eating, preparation of special diets, changing catheters, and supervision over self-administration of medications not requiring constant attention of trained medical personnel. It is care that can be taught to a lay person who does not have any professional qualifications, skills or training.)

Other Covered Medical Services and Supplies

Covered services and supplies include:

- Outpatient professional nursing services of a NETWORK PROVIDER that are certified as MEDICALLY NECESSARY covered health services by your PHYSICIAN.
- Services of a licensed nurse midwife working under the direction of a physician (for the KPIC HAP, both midwife and physician must be network providers). Does not include services of a lay midwife or a doula.
- Medically necessary covered health services of a network provider who is a licensed physical or occupational therapist, when provided by someone other than a close relative or someone who resides in your home, when ordered by a network physician, and when judged by the physician to be subject to significant improvement through such therapy. The therapy must be expected to result in significant, objective, measurable physical improvement in the covered person's condition within two months of the start of the treatment. You pay 10% subject to deductible, for the first five visits and 20%, subject to deductible, for the sixth visit in a calendar year and thereafter. (For purposes of determining coinsurance rates, tallying of the first five visits does not begin until the deductible has been met.) Services may be reviewed by the claims administrator for medical necessity and must be deemed medically necessary to be covered.

  For Anthem HAP members: After 24 visits in a calendar year, you must obtain PRE-AUTHORIZATION for additional visits in the same calendar year.
- Hearing aids and exams are covered at 20%, subject to deductible, as well as exams to determine the need for hearing aids or the need to adjust them. Cochlear implants for adults and children (age 2 or older) are also covered at 20%, subject to deductible, for the following diagnoses: (1) severe to profound bilateral sensorineural hearing loss and severely deficient speech discrimination; or (2) post-lingual deafness in an adult. Hearing aid hardware is limited to one hearing aid per ear every three years.
- For the KPIC HAP, cochlear implants — criteria for cochlear implant evaluation (required):
  - Pediatric (12–24 months):
    - bilateral profound sensorineural hearing loss
    - hearing aid trial for more than three months
  - Pediatric (2–17 years):
    - bilateral severe–profound sensorineural hearing loss
    - consistent hearing aid use for more than three months
  - Adults:
    - pure tone average (500, 1k, 2k Hz) greater than 70 dBHL, bilaterally
    - word recognition score of less than 40% in better ear
    - hearing aid trial for more than three months, except in the case of a sudden hearing loss
- Non-experimental inpatient drugs and medicines which are approved by the Food and Drug Administration (FDA). KPIC HAP members may receive coverage for drugs that are on the Kaiser Permanente formulary list.
- Non-human and artificial limbs or eyes, when determined to be a medically necessary covered health service.
- Rental or purchase of durable medical equipment (including prosthetic and orthotic devices, but not foot orthotics, which are excluded from coverage) that is ordered by a physician, approved and determined by Anthem Blue Cross or KPIC, to be a medically necessary covered health service, and is to be used solely by the patient. For Anthem HAP members, pre-authorization is required for the purchase or cumulative rental of durable medical equipment for which the total price is equal to or greater than $1,000; there will be a $300 penalty if pre-authorization is not obtained. In addition, if an item is rented, the rental price for the entire rental period cannot be more than the purchase price. The rented item must be returned if the member switches plans. Necessary repairs and maintenance of purchased equipment are also covered if not provided under a manufacturer's warranty or purchase agreement.

- Wigs and toupees for alopecia areata or alopecia resulting from chemotherapy or radiation therapy.
- For Anthem HAP members: Initial pair of eyeglasses or contact lenses prescribed by a doctor after eye surgery; For Kaiser HAP members: Contact lenses are provided after aphakia/aniridia surgery only.
- Eyeglasses or lenses when needed to replace loss of the natural lens. For KPIC HAP members, this benefit is available only for children from birth to age 9, with a limit of six contact lenses per eye per calendar year.
- For KPIC HAP members: Lenses to treat the absence of eye iris. Limit of two sets of lenses every 12 months.
- Rental of dialysis equipment and all medically necessary covered health services and supplies required for dialysis treatment.
- Oxygen, including its administration.
- Short-term speech therapy services rendered by a network certified speech therapist when required due to surgery, illness, injury, or previous therapeutic processes, when ordered by a network physician, and when judged by the physician to be subject to significant improvement through such therapy. Speech therapy due to functional nervous disorders is not covered. The therapy must be expected to result in significant, objective, measurable improvement in the covered person's condition within two months of the start of the treatment. You pay 10%, subject to deductible, for the first five visits and 20%, subject to deductible, for the sixth visit in a calendar year and thereafter. (For purposes of determining coinsurance rates, tallying of the first five visits does not begin until the deductible has been met.) Services will be reviewed by the claims administrator for medical necessity and must be deemed medically necessary to be covered. In addition, after 24 visits in a calendar year, Anthem HAP members must obtain pre-authorization for additional visits in the same calendar year.
- For Anthem HAP members, mental health and substance abuse treatment benefits are covered under the Plan, but these benefits are available through ValueOptions rather than Anthem Blue Cross. For KPIC HAP members, mental health and substance abuse benefits are administered by both KPIC and ValueOptions. See "Mental Health and Substance Abuse Coverage" on page 155 for more information.
- Applied Behavioral Analysis (ABA) is covered under the Plan, but ABA benefits are not administered by Anthem Blue Cross. For Anthem HAP members, benefits for ABA are available through ValueOptions. For KPIC HAP members, you have the option to receive ABA benefits through ValueOptions or KPIC. See "Mental Health and Substance Abuse Coverage" on page 155 for more information.
- Diabetes self-management education programs.
- Surgery to change an individual's appearance when the purpose is:
  - to correct the result of an ACCIDENTAL INJURY; or
  - to treat a condition, including a birth defect, that impairs the function of a body organ.
- Diagnostic procedures for the prenatal diagnosis of genetic disorders of the fetus when authorized by a participating physician in the case of high-risk pregnancy.
- Surgical treatment of morbid obesity when authorized by a network physician and approved by Anthem Blue Cross or KPIC, as applicable, when surgical treatment of morbid obesity is necessary to treat another life-threatening condition involving morbid obesity, and when it has been documented that non-surgical treatments of the morbid obesity have failed. For bariatric surgery, there is a transportation and lodging benefit of up to $3,000 available (pre-authorization required; contact your plan administrator for more information).
- INFERTILITY treatments, up to a lifetime maximum of $7,000 combined. The benefit includes, but is not limited to, in vitro fertilization services, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and artificial insemination/microinjection techniques. Services provided must be considered safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications.

- Coverage for routine mammographies (given as preventative measures to detect problems when a network physician does not have a specific reason to suspect a medical problem), in accordance with Anthem Blue Cross or KPIC's standard administrative policies. Diagnostic mammographies, which are given when there is a suspected problem, are covered as well.
- Transgender surgery, if the surgery meets all the criteria for being deemed medically necessary by Anthem Blue Cross or KPIC, as applicable. There is a transportation and lodging benefit of up to $3,000 available (pre-authorization required; contact your plan administrator for more information).
- Routine services during a qualified clinical trial for cancer or another life-threatening condition will be covered to the same extent as those services for members who are not enrolled in clinical trials. Clinical trial drugs are not a covered benefit under HAP since they are paid for by the pharmaceutical company sponsoring the trial. Investigational items or services related to the clinical trial, items and services provided solely for data collection and analysis and that are not used in the direct clinical management of the patient, and services which are clearly inconsistent with widely accepted and established standards of care for the patient's diagnosis are not covered.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending PHYSICIAN and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

Coverage of breast reconstruction will be provided subject to the deductibles and coinsurance benefit limits consistent with those established for other benefits under your plan. For more information, contact your HAP claims administrator directly.

Newborns' and Mothers' Health Protection

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any HOSPITAL length of STAY in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

What the HAP Doesn't Cover

Unless exceptions to the following are specifically noted elsewhere in this Handbook, no benefits are provided for the following:

- For KPIC HAP members, any non-emergency service received from a non-network provider or facility, unless such services are Authorized Referrals, emergencies or out-of-area URGENT CARE. For details, see "Emergency, Post-Stabilization, and Out-of-Area Urgent Care Received from Non-Network Providers – KPIC HAP" on page 130.
- Services or supplies received from a provider or supplier who is not licensed, registered or certified under state law to the extent required to provide such service or supply, or if the service or supply provided is not within the scope of the provider's license, certificate or registration.
- Services or supplies that are not covered health services, which include all services that are not MEDICALLY NECESSARY (see "What the HAP Covers" on page 142) or that are educational in nature, as determined by Anthem Blue Cross or KPIC.
- For Anthem HAP members, charges in excess of the reasonable and customary charges (R&C), as determined by Anthem Blue Cross (see "How the HAP Works" on page 125 and the definition of "ELIGIBLE EXPENSES" in the "Glossary" on page 174), for services rendered by non-preferred providers.
- For KPIC HAP members, charges in excess of eligible charges, as determined by KPIC (see "How the HAP Works" on page 125 and the definition of "ELIGIBLE EXPENSES" in the "Glossary" on page 174)
- Services that are provided or a hospitalization that begins before coverage begins or after it ends, except as specifically noted elsewhere or unless the coverage began under another Company-sponsored medical plan.
- Hospitalization that continues after coverage has ended and after you have recovered sufficiently to be discharged, unless you are certified as totally disabled as explained in "Extended Benefits When Coverage Ends" in the *Health Care Participation* section.
- Hospitalization primarily for physical therapy or other rehabilitative care, unless approved by Anthem Blue Cross or KPIC as a medically necessary covered health service, except those benefits which would have been provided had the patient been treated on an outpatient basis. For example, charges for room and board during such a hospitalization are not covered.
- Services or supplies in connection with custodial care. Custodial care is defined as care provided primarily to assist an individual in meeting the activities of daily living including, but not limited to, walking, bathing, dressing, eating, preparation of special diets, changing catheters, and supervision over self-administration of medications not requiring constant attention of trained medical personnel. It is care that can be taught to a lay person who does not have any professional qualifications, skills or training.
- Services in connection with the reversal of voluntary sterilization.
- Services or supplies which would not have been rendered or furnished if the Plan did not exist or services or supplies for which you would not have been required to pay.
- Cosmetic procedures are excluded from coverage. Procedures that correct a congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, illness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.
- For Anthem HAP members, notify your claims administrator five business days before receiving services from a NON-NETWORK PROVIDER. By notifying your claims administrator, it can be verified whether a service is a reconstructive or a cosmetic procedure.
- Services or supplies furnished in connection with cosmetic surgery or surgery performed mainly to change appearance. This includes surgery performed to treat a mental, psychoneurotic, or personality disorder through a change in appearance. The following are not considered to be cosmetic surgery:

  - Surgery to correct the result of an ACCIDENTAL INJURY;
  - Surgery to treat a condition, including a birth defect, that impairs the function of a body organ; or
  - Surgery to reconstruct a breast after a mastectomy.
- Services and supplies furnished in connection with surgical procedures for gender reassignment surgery, unless medically necessary as determined by Anthem Blue Cross or KPIC.
- Personal comfort and convenience items and services such as guest meals, television rental or barber services.
- Reimbursement for meal expenses incurred in connection with the travel benefit for transplants, bariatric surgery or transgender surgery.
- Medical or surgical treatment of excessive sweating (hyperhidrosis) except when medically necessary.
- Nutritional counseling, except when related to the treatment of diabetes or an approved bariatric surgery.
- Dental and orthodontia services, including braces, bridges, and guards, or X-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process, or the gums. This applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as the treatment of Temporomandibular Joint Disorders (TMJD) or malocclusion involving joints or muscles by methods including, but not limited to, crowning, wiring or repositioning teeth.
  - This exclusion does not apply to services for treatment or removal of a malignancy; physicians' services or X-ray exams for treatment of accidental injury to natural teeth ("treatment" includes the replacement of those teeth), provided the participant is covered by the Plan, the accident occurred while covered, and the treatment is received within 12 months of the accident; or surgery on the maxilla or mandible that is medically necessary to correct TMJD or other medical disorders.
- Any services in connection with medical exams or tests not connected with the care and treatment of an actual illness, disease, or injury, except services that Anthem Blue Cross or KPIC as Claims Administrator determines are standard preventive or well-care services (such as annual physical examinations, mammograms and colonoscopies) that are provided in accordance with Anthem Blue Cross or KPIC's guidelines. Diagnostic procedures are covered for the prenatal diagnosis of genetic disorders of the fetus when authorized by a preferred provider in the case of high-risk pregnancy.
- Services or supplies for or in connection with:
  - Exams to determine the need for (or changes of) eyeglasses or lenses of any type (Anthem HAP only);
  - Eyeglasses or lenses of any type except as follows:
    - Eyeglasses or lenses when needed to replace loss of the natural lens (for Kaiser members, this benefit is only available for children from birth to age 9);
    - For Anthem HAP members: the initial pair of eyeglasses or contact lenses after eye surgery;
    - For Kaiser HAP members:
      - Contact lenses provided after aphakia or aniridia surgery only
      - Lenses to treat the absence of eye iris (limit of two every 12 months)
  - Eye surgery such as radial keratotomy or lasik surgery; or
  - Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services or supplies given in connection with, or related to, the surgery.
- Services or supplies furnished by the employer or a member of the participant's immediate family.
- Services that do not meet the definition of covered health services.

- Any services or supplies that are considered to be "experimental" or "investigational," as determined solely by Anthem Blue Cross or KPIC. EXPERIMENTAL PROCEDURES are defined as procedures that are mainly limited to laboratory and/or animal research. Investigational services include any treatment, therapy, procedure, drug, facility, equipment, device or supply that is not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of an illness, injury or condition. Investigational services also include those which require approval by the federal government or any agency thereof, or by any state governmental agency, prior to use, and where such approval has not been granted at the time the services were rendered.
- Speech therapy that is not determined to be a medically necessary covered health service, as determined solely by Anthem Blue Cross or KPIC.
- Physical and/or occupational therapy that is not determined to be a medically necessary covered health service, as determined solely by Anthem Blue Cross or KPIC.
- Massage therapy, if performed by a massage therapist, or any services performed by a massage therapist who is not also a PHYSICIAN or other approved health care provider (see the "Glossary" on page 174). However, massage therapy performed by a physical therapist or chiropractor is covered, if deemed to be medically necessary by Anthem Blue Cross or KPIC.
- Any services or supplies for learning disabilities, mental retardation, or hospitalization for environmental change except for Applied Behavioral Analysis (ABA) or speech/occupational/physical therapy rendered in association with autistic spectrum disorder. Services and supplies in connection with mental, behavioral, psychoneurotic, and personality disorders, and for abuse of or addiction to alcohol and drugs, are not covered by Anthem as medical services but are covered elsewhere by the Plan under the Mental Health and Substance Abuse treatment provisions administered by ValueOptions.
- Any services or supplies furnished in connection with foot care, unless they are determined to medically necessary covered health services and ordered by your attending physician.
- Orthopedic shoes (except when joined to braces) or shoe inserts, such as orthotics, even if recommended by your physician, unless for diabetes-related conditions.
- Services or supplies that are not determined to be covered health services, including any confinement or treatment given in connection with a service or supply that is not covered under the Plan.
- Exercise programs, exercise monitoring, exercise equipment, and health spa programs. Outpatient dietary consultations are also excluded unless medically necessary.
- Services or supplies primarily for weight reduction or treatment of obesity, unless they are determined to be medically necessary covered health services and authorized by a NETWORK PROVIDER and Anthem Blue Cross or KPIC. This exclusion will not apply to surgical treatment involving morbid obesity if:
  - surgical treatment of morbid obesity is necessary to treat another life-threatening condition involving morbid obesity, and
  - it has been documented that non-surgical treatments of the morbid obesity have failed, and
  - surgical treatment has been approved by Anthem Blue Cross or KPIC.
- Heating pads and thermometers, and other over-the-counter products.
- Devices and computers to assist in communication and speech.
- Air purifiers, air conditioners and humidifiers.
- Supplies for comfort, hygiene or beautification.
- Services and supplies furnished in connection with injury or disease arising out of, or in the course of, any work for wage or profit (whether or not with the employer) if such injury or disease is covered by any Workers' Compensation law, occupational disease law or similar law. The HAP claims administrator will provide services and supplies in connection with such injury or disease but will be entitled to reimbursement for them in accordance with rules set out in The Pacific Gas and Electric Company Health Care Plan for Active Employees Plan Document.

- Treatment for conditions caused by war or aggression, declared or undeclared, or international armed conflict.
- Services or supplies to the extent furnished by any law or government, unless required by law.
- Benefits provided under the "Medicare" section of the Social Security Act.
- Services and supplies for which coverage is available under any other Company-sponsored health plan or benefit program.
- Alternative treatments such as acupressure, aromatherapy, hypnotism, rolfing and other forms of alternative treatment, as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Charges for failure to keep a scheduled appointment, transfer of medical records, and other similar charges for which no medical treatment or services have been provided.
- Services that are educational in nature, unless specifically authorized by Anthem Blue Cross or KPIC.
- Except as otherwise provided herein for preventive and well-care exams and tests, any services in connection with routine physical exams or medical exams not connected with the primary purpose of the discovery of a medical condition, disease or illness leading to treatment, such as a pre-employment medical exam or a team sports exam.
- Benefits provided under the extension of a benefits provision of other insurance policies, benefit plans, or health plan contracts.

See "Reductions/Exclusions for Duplicate Coverage" in the *Health Care Participation* section.

Mental Health and Substance Abuse Coverage

The Company provides mental health and substance abuse treatment for you and your Eligible Dependents.

The way you receive mental health and substance abuse benefits ("behavioral health coverage") depends on which Health Account Plan (HAP) claims administrator you have selected. You and your Eligible Dependents are automatically enrolled in the appropriate program when you enroll in the HAP. ValueOptions, a behavioral health managed care company, is the primary administrator of your mental health and substance abuse coverage if you are in the Anthem HAP. If you are in the KPIC HAP, KPIC will be your primary administrator of your mental health and substance abuse coverage (see "What the HAP Covers" on page 142 for additional information).

EAP Coverage Is Separate

In addition to the mental health and substance abuse you have through your Health Account Plan (HAP), you also have access to counseling and other mental health resources through the Employee Assistance Program (EAP). The EAP is available even if you decline medical coverage. For details, see the *Employee Assistance Program (EAP)* section.

To differentiate behavioral health treatment from medical treatment, the following is needed:

- The diagnosis must be in the DSM 5 (Diagnostic and Statistical Manual, Fifth Edition)
- Services must be provided by an independently licensed mental health provider using services codes specific to psychotherapy and psychiatry. For example:
  - If someone receives treatment for depression from his or her PCP or general practitioner, it is not covered by ValueOptions because the provider is not a mental health provider.
  - If someone receives educational testing by a psychologist, it is not covered because educational testing is not covered under the Plan.
  - If someone receives treatment by a psychologist for pain related to a medical condition, i.e., the diagnosis is not in the DSM 5, it is not covered under the Plan.
  - If someone is treated for a drug-overdose due to a suicide attempt, the medical services (stomach pump, injections, and medical observation) are covered under the medical provisions of the HAP; however, a psychiatric evaluation performed by a psychiatrist to evaluate the potential danger to the person being treated would be covered by the mental health and substance abuse provisions.

There are no lifetime benefit limits, and no pre-existing exclusions.

How Benefits Are Provided

The way mental health and substance abuse benefits are provided depends on which HAP claims administrator you selected and the type of care you need.

If you are in the Anthem HAP

Mental health and substance abuse treatment is administered by ValueOptions. Coverage begins on the same date as your medical plan coverage. You and your dependents may also seek services through the Employee Assistance Program (EAP), which is available to all active employees, their spouses/registered domestic partners, and their Eligible Dependents. For details, see the *Employee Assistance Program (EAP)* section.

If you are in the KPIC HAP

All mental health services, including inpatient and alternate levels of care, structured outpatient or partial hospitalization, and outpatient substance abuse treatment are provided directly through KPIC. Coverage begins on the same date as your medical plan coverage. You and your dependents may also seek services through the

Employee Assistance Program (EAP), which is available to all active employees, their spouses/registered domestic partners, and their Eligible Dependents. For details, see the *Employee Assistance Program (EAP)* section.

For substance abuse treatment:

- Kaiser Permanente provides outpatient detoxification services, intensive or structured outpatient services and partial hospitalization for substance abuse treatment.
- ValueOptions provides detoxification, inpatient or residential substance abuse treatment. Services must be pre-approved by ValueOptions or an on-site EAP counselor; otherwise, no coverage is provided. Coverage begins on the same date as your medical plan coverage.

KPIC Mental Health and Substance Abuse Treatment	
Treatment	**Administrator**
Inpatient and Alternate Levels of Care for Mental Health	Kaiser Permanente
Outpatient Mental Health	
Inpatient and Residential Level of Substance Abuse	ValueOptions
Medically Necessary Detoxification for Substance Abuse	ValueOptions
Intensive or Structured Outpatient, Partial Hospitalization and Outpatient Substance Abuse	Kaiser Permanente
Autism Applied Behavior Analysis	ValueOptions or KPIC (member's choice)

To receive benefits that are provided through KPIC, you must go through the KPIC medical management process.

In order to receive benefits from the ValueOptions program for any alternate levels of care (including partial hospitalization, residential, intensive and structured outpatient care), eligible HAP members must receive a referral or authorization from ValueOptions or an on-site EAP counselor. ValueOptions is also the administrator of the Employee Assistance Program (EAP). For details, see the *Employee Assistance Program (EAP)* section.

Deductibles, Limits, and Coinsurance

The following charts summarize your mental health and substance abuse treatment benefits if you are enrolled in the HAP.

- For Anthem HAP members, benefits are based on ELIGIBLE EXPENSES. See "Eligible Expenses" under "What Is Covered Under the HAP" on page 160.
- For KPIC HAP members, benefits are based on eligible charges. See "Eligible Charges" under "What Is Covered Under the HAP" on page 160.

If You Are in the Anthem HAP

Provision	Benefit	Administrator
Outpatient Mental Health Treatment (Institutional & Professional, Intensive Outpatient, Day Treatment)	▪ You pay 10% of covered charges, no deductible ▪ Requires authorization by ValueOptions ▪ Applies to combined out-of-pocket maximum	▪ ValueOptions
Inpatient Mental Health Treatment (Institutional, Residential Treatment Center)	▪ You pay 20% of covered charges, after medical plan deductible ▪ Requires authorization by ValueOptions; $300 penalty if you fail to notify within 48 hours ▪ Covers emergency room services at 80% after deductible, for services coded with Mental Health and Substance Abuse (MHSA) code ▪ No limit on number of stays ▪ Applies to combined out-of-pocket maximum	▪ ValueOptions
Autism Applied Behavior Analysis (ABA)	▪ Fully covered (no deductible) ▪ Requires authorization by ValueOptions	▪ ValueOptions
Outpatient Substance Abuse (Outpatient, Day Treatment, and Intensive Outpatient)	▪ You pay 10% of covered charges, no deductible ▪ Requires authorization by ValueOptions ▪ No visit limit ▪ Applies to combined out-of-pocket maximum	▪ ValueOptions
Inpatient Substance Abuse (Detoxification, Institutional and Residential Treatment)	▪ You pay 20% of covered charges, after medical plan deductible ▪ Requires authorization by ValueOptions; $300 penalty if you fail to notify within 48 hours ▪ Covers emergency room services at 80% after deductible, for services coded with Mental Health and Substance Abuse (MHSA) code. ▪ No limit on number of stays ▪ Applies to combined out-of-pocket maximum	▪ ValueOptions
DOT- or NRC-Mandated Alcohol/Substance Abuse Treatment	▪ Fully covered (no deductible) ▪ Requires authorization by ValueOptions or an on-site EAP counselor	▪ ValueOptions

If you are in the KPIC HAP

Provision	Benefit	Administrator
Outpatient Mental Health Treatment **(Institutional & Professional, Intensive Outpatient, Day Treatment)**	▪ You pay 10% of covered charges, no deductible ▪ Requires authorization by KPIC ▪ Applies to combined out-of-pocket maximum	▪ Kaiser Permanente
Inpatient Mental Health Treatment **(Institutional, Residential Treatment Center)**	▪ You pay 20% of covered charges, subject to deductible ▪ Requires authorization by KPIC ▪ Applies to combined out-of-pocket maximum	▪ Kaiser Permanente
Autism Applied Behavior Analysis (ABA)	▪ Fully covered (no deductible) ▪ Requires authorization by plan	▪ KPIC or ValueOptions
Outpatient Substance Abuse (Outpatient, Day Treatment, and Intensive Outpatient)	▪ You pay 10% of covered charges, no deductible ▪ No visit limit ▪ Applies to combined out-of-pocket maximum	▪ KPIC
Inpatient Substance Abuse (Detoxification, Institutional and Residential Treatment)	▪ You pay 20% of covered charges, subject to deductible ▪ Requires authorization by ValueOptions; $300 penalty if you fail to notify within 48 hours ▪ Provides detoxification, inpatient, and residential treatment ▪ No limit on number of stays ▪ Applies to combined out-of-pocket maximum	▪ ValueOptions
DOT- or NRC-Mandated Alcohol/Substance Abuse Treatment	▪ Fully covered (no deductible) ▪ Requires authorization by ValueOptions or an on-site EAP counselor	▪ Value Options – inpatient treatment ▪ Kaiser Permanente – outpatient treatment

Applied Behavioral Analysis (ABA) is a type of treatment for autism that emphasizes behavioral training and management through positive reinforcement, self-help, and social skills training. ABA is used to help improve behavior, communication, and overall function. ABA for the treatment of autism is fully covered (no deductible) under both administrators.

Please note that ValueOptions (VO) is the Claims Administrator only for the mental health and substance abuse benefits that are included under the Anthem HAP and for the Institutional, Residential and Inpatient substance abuse treatment included under the KPIC HAP.

For details on the benefits provided by the HAP, call your HAP claims administrator's member services number.

How to Obtain Benefits

If you are in the Anthem HAP, you must obtain authorization from ValueOptions for all inpatient and outpatient mental health and substance abuse treatment, except for alternate levels of care (partial hospitalization, residential treatment, and intensive or structured outpatient care), for which ValueOptions or an on-site EAP counselor can provide authorization.

To obtain authorization and receive benefits, contact one of the following:

- ValueOptions (VO) by calling 800-562-3588 to speak with a VO care manager who will coordinate your case; or
- An on-site EAP counselor during normal business hours (please see the *Employee Assistance Program (EAP)* section).

VO care managers are available 24 hours a day, seven days a week to assist you. Your case will be confidential, except as otherwise provided by law or as noted in any paperwork you may complete.

Care managers are qualified, licensed professionals, including psychologists, psychiatric social workers, marriage and family counselors and registered psychiatric nurses. The care manager can assess your particular situation and concerns, and discuss various treatment options with you. They can also help you find appropriate network providers in your area.

Although you need authorization from ValueOptions for all outpatient treatment, you may also browse through ValueOptions' network of providers yourself by accessing ValueOptions' website for PG&E members at https://www.achievesolutions.net/pge. When you first access the site, select "About Services," and then "Find Services." Then select "Referral Connect" under "Mental Health." You can use various selection criteria, such as geographic location and provider's specialty, to help find an appropriate provider. Should you need assistance in establishing an appointment, the ValueOptions Access Team can assist you. Call the toll-free number and let the care manager know you need help.

Remember, you receive benefits only when your care is authorized by ValueOptions.

If you are in the KPIC HAP, you must obtain authorization from:

- Kaiser Permanente for all inpatient and outpatient mental health treatment;
- Kaiser Permanente for and outpatient substance abuse treatment, including intensive or structured outpatient care or day treatment;
- ValueOptions or an on-site EAP counselor for residential or inpatient substance abuse treatment.

For more information on medical management and the authorization process, see "Medical Management Programs" on page 133.

In Case of Emergency

If you or any of your covered dependents require emergency treatment and/or a HOSPITAL admission for a mental health condition, your first concern should be to seek professional help immediately.

If you are in the Anthem HAP, you should then contact ValueOptions within 48 hours to request network benefits for the emergency treatment. Failure to obtain authorization within 48 hours of confinement or treatment for any higher level of care (that is, inpatient care, partial hospitalization, residential treatment, intensive or structured outpatient care), will result in a $300 penalty. This penalty applies to both Mental Health and Substance Abuse treatment as well as to care provided by either network or NON-NETWORK PROVIDERS.

If you're in the KPIC HAP, you do not need PRE-AUTHORIZATION for emergency services. The Plan covers emergency services from NETWORK PROVIDERS or non-network providers anywhere in the world, as long as the services would have been covered under the Plan if you had received them from network providers. If you have been admitted to a non-network hospital, your STAY will be covered if KPIC is notified and authorization is given within 24 hours or as soon as reasonably possible of stabilization of your condition. Failure to obtain authorization will result in a $300 penalty.

What Is Covered Under the HAP

Eligible Expenses

For the Anthem HAP, ELIGIBLE EXPENSES, are:

- expenses for covered health services that are covered by the Plan,
- those expenses that ValueOptions considers MEDICALLY NECESSARY for diagnosis or treatment; and
- those that do not exceed the "reasonable and customary" rate, as determined by Value Options.

Eligible Charges

For the KPIC HAP, eligible charges are:

- For services provided by KPIC, the charge in the relevant Kaiser Foundation Health Plan's schedule of Kaiser Permanente charges for services provided to participants;
- For services that NETWORK PROVIDERS (other than KPIC) provide under a contract with Kaiser Permanente, the amount that the provider has agreed to accept as payment in full under that contract;
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge you for the item if your benefits did not cover the item; and
- For all other services, the amounts that KPIC allows for the services.

Any costs not meeting these guidelines as outlined by Anthem Blue Cross and KPIC, respectively, are the responsibility of the member. For additional information or questions, call ValueOptions or KPIC, as applicable.

Benefits

Mental health expenses covered under the program include:

- Inpatient treatment;
- Residential Treatment centers;
- Day centers; and
- Outpatient treatment (Institutional, Professional, and Intensive).

Substance abuse treatment expenses covered under the program include:

- Outpatient treatment;
- Alternate Levels of Care:
  - Partial hospitalization;
  - Residential programs; and
  - Intensive and structured outpatient treatment
- Medically necessary detoxification (inpatient); and
- Inpatient hospitalization.

You receive benefits only if:

- you have obtained a referral to a network provider through the appropriate party: a VO care manager (800-562-3588) or an EAP on-site counselor, or through KPIC, whichever is applicable;
- your treatment plan is medically necessary (see "Medically Necessary Services" on page 128) and is approved by the appropriate party: a VO care manager or one of the Company's on-site EAP counselors, or by KPIC, whichever is applicable; and
- the primary diagnosis is a mental health condition, alcoholism or drug dependency.

All benefits require referrals or authorization from ValueOptions or KPIC, as applicable.

Mental Health

If you are eligible to receive benefits for any mental health treatment through this Program, you must obtain authorization from ValueOptions, an on-site EAP counselor, or KPIC, as applicable.

Inpatient

For inpatient mental health treatment, after your HAP's deductible has been satisfied, you pay 20% for authorized treatment. Authorization is required from ValueOptions or KPIC, as applicable.

Outpatient

For outpatient mental health care through ValueOptions or KPIC, as applicable, you pay 10%. No deductible is applied. Authorization is required from ValueOptions or KPIC, as applicable.

Alcohol and Drug Dependency

If you are eligible to receive benefits for any substance abuse treatment through this Program, you must obtain authorization from ValueOptions, an on-site EAP counselor, or KPIC, as applicable. Authorization for inpatient or Alternate Levels of Care (partial hospitalization, residential treatment, and intensive or structured outpatient care) is required. KPIC HAP members receive any outpatient substance abuse care, partial hospitalization or structured outpatient levels of care services through Kaiser Permanente, not through ValueOptions. They are eligible to receive inpatient, residential and medically necessary inpatient detoxification care through the program administered by ValueOptions.

Inpatient

For inpatient or residential treatment program substance abuse care, after your HAP's deductible has been satisfied, you pay 20% for authorized treatment. There is no limit on the number of stays. Authorization from VO is required. For Anthem HAP members, there will be a $300 penalty applied if PRE-AUTHORIZATION is not obtained within 48 hours of confinement or treatment.

Alternate Levels of Care

For substance abuse alternate levels of care, you pay 10% for partial hospitalization programs and intensive or structured outpatient services. No deductible is applied. You pay 20% for residential treatment programs after the ANNUAL DEDUCTIBLE has been satisfied. Authorization from ValueOptions is required. There is no maximum on the number of stays, programs, or services.

Outpatient

For outpatient substance abuse care through ValueOptions or KPIC, as applicable, you pay 10%. No deductible is applied. There is no maximum on the number of visits.

Medical Management and Authorization Programs

Benefits are provided only for MEDICALLY NECESSARY and appropriate services. (See "How the HAP Works" on page 125.)

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and payment of benefits is subject to all the terms and requirements of the benefit plan.

For Anthem HAP Members

Authorization

Authorization is required for all higher levels of care, including inpatient, alternate levels of care (residential treatment, partial hospitalization, and intensive or structured outpatient care), psychological testing, and electric convulsive therapy (ECT). Authorization establishes that the treatment has met the medical necessity criteria.

Failure to obtain authorization for a confinement or treatment for any higher level of care (e.g., inpatient care, partial hospitalization, residential treatment, intensive or structured outpatient care) could result in the services or treatment not being covered. For this reason, it is important to obtain authorization prior to receiving services or treatment. There will be a $300 penalty applied if PRE-AUTHORIZATION is not obtained within 48 hours of confinement or treatment.

Utilization Review

The Utilization Review process evaluates the ongoing medical necessity and appropriateness of care and the setting in which care is provided. Services that are medically necessary and appropriate are certified by ValueOptions and monitored so that you know when it is no longer medically necessary and appropriate to continue those services.

Concurrent Review

The concurrent review process provides authorization for a determined time period depending on the level of care. Prior to the end of the authorization, the provider must contact ValueOptions to provide updated information on which ValueOptions can base its decision to authorize or deny the treatment. Failure to obtain the authorization will result in the claim being denied. Remember, you are responsible for the payment of services rendered until there is an authorization provided by ValueOptions.

Retroactive Review

The retroactive review process can be used in circumstances in which authorization was not established prior to the services being provided. In that case, you can request the retroactive review and provide written authorization to release the clinical records to ValueOptions. Once the records are received, ValueOptions will review the information and make a determination as to whether medical necessity has been established. If medical necessity is not established, then the claims will be denied. If medical necessity is established, the claims will be paid according to the benefit plan provisions. There will be a $300 penalty applied if PRE-AUTHORIZATION was not obtained.

For KPIC HAP Members

Utilization Review Program

The Utilization Review Program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your PHYSICIAN are advised if it has been determined that services can be safely provided in an outpatient setting or if an inpatient STAY is recommended. Services that are MEDICALLY NECESSARY and appropriate are certified by KPIC and monitored so that you know when it is no longer medically necessary and appropriate to continue those services.

Pre-Authorization

Pre-authorization is medically necessary approval obtained in advance which is required for certain services to be covered services under the Health Account Plan (HAP). Pre-authorization is not a guarantee of payment and will not result in payment for services that do not meet the conditions for payment by the HAP as determined by the Claims Administrator. Your KPIC physician will request pre-authorization when it is required. There will be a $300 penalty applied if PRE-AUTHORIZATION is not obtained within 48 hours of confinement or treatment.

If you are in the KPIC HAP and are receiving care from ValueOptions, please refer to the instructions for Anthem HAP members above.

Medically Necessary

For the purpose of this program, MEDICALLY NECESSARY services are those that are:

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (ICD-9 or DSM 5) that threatens life, causes pain or suffering, or results in illness or infirmity.
- Expected to improve an individual's condition or level of functioning.
- Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of the patient's needs.
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
- Reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available.

- Not primarily intended for the convenience of the recipient, caretaker, or provider.
- No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

What Is Not Covered Under the Mental Health/Substance Abuse Provisions of the HAP

The following list includes, but is not limited to, services for which the Plan will not pay:

- Any services performed by a non-licensed provider for mental health or substance abuse treatment.
- Treatment programs for which the primary diagnosis is not a mental health condition, alcoholism, or drug dependency (although services for other diagnoses may be covered under the medical provisions of the Plan).
- Treatment programs which are not certified as MEDICALLY NECESSARY.
- Services for growth/personal exploration or learning disabilities, except for Applied Behavioral Analysis (ABA).
- Mental health and substance abuse treatment in a group home or halfway house.
- Treatment that does not meet the national standards established by mental health or substance abuse treatment professionals, or treatment that is deemed to be experimental.
- Court-ordered testing and treatment (unless otherwise covered and medically necessary).
- Services or supplies rendered or furnished before the patient became covered by the Program or after the patient's coverage terminated.
- Treatment for tobacco addiction or treatment of eating disorders, except disorders listed in the DSM 5.
- Ancillary services for vocational rehabilitation, behavioral training and employment counseling.
- Medical detoxification that must be provided in an acute medical unit of a HOSPITAL. (This expense is covered under the medical provisions of the HAP.)
- For the Anthem HAP:
  - Charges in excess of reasonable and customary fees, or NEGOTIATED RATES in the case of a NETWORK PROVIDER see How the HAP Works" on page 125 and the definition of "ELIGIBLE EXPENSES" in the "Glossary" on page 174);
  - Hypnotherapy;
  - Second opinions (inpatient or outpatient);
  - Outpatient services rendered outside of the United States are not covered unless urgent or emergent. Inpatient services rendered outside of the United States are not covered under any circumstances.
- For the KPIC HAP, charges in excess of eligible charges, as determined by KPIC (see "How the HAP Works" on page 125 and the definition of "eligible charges" in the "Glossary" on page 174)
- Outpatient or take-home prescription drugs and medicines, outpatient diagnostic laboratory tests, and ambulance transportation for covered conditions. (These expenses may be covered under the medical or prescription drug provisions of the HAP)
- Any conditions for which benefits are recoverable under Workers' Compensation or any similar law.
- Treatment of a family member other than as a patient (unless it is part of an approved treatment plan for the patient).
- Psychological testing, unless determined to be both appropriate and medically necessary by the claims administrator and authorization is obtained.
- Outpatient ElectroConvulsive Therapy (ECT), unless determined to be both appropriate and medically necessary by the claims administrator and authorization is obtained.

- Custodial care for a mental health condition. Custodial care is defined as care rendered to a patient who:
  - is disabled mentally or physically, and such disability is expected to continue and to be prolonged; and
  - requires a protected, monitored and controlled environment, whether in an institution or in the home; and
  - requires assistance to support the essentials of daily living; and
  - is not under active and specific medical/surgical or psychiatric treatment which will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

A custodial care determination is not precluded by the fact that a patient is under the care of a supervising or attending PHYSICIAN and that services are being ordered and prescribed to support and generally maintain the patient's comfort. Further, a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Visiting Nurse (L.V.N.).

More About Mental Health and Substance Abuse Treatment Benefits

Benefits Under Other Plans

You will never be reimbursed for more than 100% of allowed charges for your covered expenses.

In addition, if your primary coverage is under another plan and this Program provides secondary coverage, you must follow the rules of this Program to receive secondary benefits.

Refer to "If You Have Other Coverage" in the *Health Care Participation* section for more information on coordination of benefits.

Third-Party Exclusion

The HAP contains an exclusion for any injury, illness or other condition for which a third party may be liable or legally responsible by reason of negligence, intentional action, or breach of legal obligation. These exclusions, limitations, and conditions are described under "Subrogation and Reimbursement" under "If You Have Other Coverage" in the *Health Care Participation* section.

Claims and Appeals Process

Note: For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Care Plan for Active Employees or to make election changes to your coverage under the Plan, see the "Claims and Appeals Process" on page 180 and the *Health Care Participation* section.

For information on how to file a claim with ValueOptions or KPIC for mental health or substance abuse coverage, please see "Filing a Claim" on page 195.

Prescription Drug Coverage

This section describes the prescription drug benefits which are offered to employees and their dependents who are enrolled in the Health Account Plan (HAP) administered by Anthem Blue Cross or KPIC.

If you are in the Anthem HAP, your prescription drug coverage is administered by Express Scripts. Express Scripts provides retail and mail-order prescription drug coverage.

If you are in the KPIC HAP, retail and mail-order prescription drug coverage is administered by KPIC. Prescription drugs must be obtained from the KPIC HAP network and appear on the KPIC list of approved drugs. For certain urgent or emergency care or as otherwise specified you may be able to obtain approved drugs outside the KPIC HAP network.

Plan Benefits

This section provides an overview of prescription drug benefits provided under the HAP for Anthem members and KPIC members.

Plan Benefits for Anthem HAP Members

The following chart provides a summary of outpatient drug coverage administered by Express Scripts.

Prescription Drug Benefits for Anthem Blue Cross HAP Members (Administered by Express Scripts)	
Retail Drug Purchases	**First three 30-day supplies** at a participating pharmacy: ▪ You pay 15% for generic drugs, 25% for brand-name drugs. **Fourth fill and beyond** of drugs **not on** mandatory mail-order drug list: ▪ You pay 15% for generic drugs, 25% for brand-name drugs. **Fourth fill and beyond** of drugs **on** mandatory mail-order drug list: ▪ No coverage for additional fills except through Express Scripts mail-order program. Through mail order, you're responsible for 10% of covered charges for generic; 20% for brand. ▪ Note: You need to use mail-order to get coverage for maintenance drugs. Generic Incentive Provision and Step Therapy Provision apply.
Mail-Order Purchases	You pay 10% for generic drugs and 20% for brand-name drugs, up to a 90-day supply Generic Incentive Provision and Step Therapy Provision apply
Generic Incentive Provision	Member is responsible for paying the difference between the price of a generic drug and a brand-name drug, plus coinsurance, if purchasing a brand-name drug when a generic version is available. Please note that any generic-brand price differential you pay is a non-covered expense and, thus, does not count towards your ANNUAL DEDUCTIBLE or out-of-pocket maximum.
Step Therapy Provision	To ensure members have access to clinically appropriate medications, the Plan requires that members try generic medication or lower-cost brand-name alternatives first, instead of higher-cost brand-name drugs. Express Scripts will review and approve exceptions if brand-name drugs are required. Members may request such a review by submitting an appeal directly to Express Scripts.

Prescription Drug Benefits for Anthem Blue Cross HAP Members (Administered by Express Scripts)	
Annual Deductible	Annual deductible coordinates with medical plan and mental health/substance abuse coverage; $1,000/individual, $2,000/family maximum. Deductible applies for all prescription drugs, except for preventive medications/devices on the HAP free drug list.
Annual Out-of-Pocket Maximum	▪ $2,400 per person, $4,800 per family. ▪ Out-of-pocket maximum coordinates with the medical plan and mental health/substance abuse coverage. Covers both retail drugs and mail-order drugs. Non-covered expenses, such as generic-brand price differentials and other penalties, are not ELIGIBLE EXPENSES and will not count toward your annual deductible or out-of-pocket maximum, nor will these expenses be covered by the Plan after your annual out-of-pocket maximum is met.
Lifetime Maximum	None
Preventive Drugs and Devices	▪ Preventive medications on the HAP Free Drug List are fully covered (no deductible) at mail order only. ▪ Contraceptive devices (including birth control) indicated on the HAP Free Drug List are considered preventive and are fully covered (no deductible) at mail order. Also available at retail pharmacies at designated retail coinsurance.
Infertility and Sexual Dysfunction Drugs	▪ You pay 50% for both retail and mail-order plans, unless MEDICALLY NECESSARY. ▪ Medically necessary drugs are covered at standard reimbursement rates. ▪ Generic Incentive Provision applies.

Express Scripts has NEGOTIATED RATES with many retail pharmacies. Benefits for prescription drugs purchased at these pharmacies are paid based on these negotiated rates. The pharmacies that Express Scripts has negotiated with are called "participating" pharmacies. To receive the greatest benefit on retail prescriptions, participating pharmacies should be used. A directory of participating pharmacies can be obtained by calling Express Scripts Member Services at 800-718-6590 or by visiting Express Scripts' website at www.express-scripts.com. You also can use the easy mail-order program for your maintenance drugs.

Manufacturer rebates are earned upon participant purchase of certain prescription drugs. The value of these rebates is based on the contract that Pacific Gas and Electric Company, as Plan sponsor, has with Express Scripts. These rebates are received from Express Scripts approximately six months after the purchase of a drug and are deposited back into the trust holding the plan assets for retirees or employees on Long-Term Disability or back to the company for active employees. The cost of the Plan is reduced by the value of the rebates.

Plan Benefits for KPIC Members

The following chart provides a summary of outpatient drug coverage administered by KPIC. Outpatient prescription drugs must be obtained from network pharmacies and must be on the KPIC formulary list (unless otherwise specified).

Prescription Drug Benefits for KPIC HAP Members (Administered by KPIC)	
Retail Drug Purchases	You pay 15% for generic drugs and 25% for brand-name drugs, for up to a 100-day supply Preventive drugs on the HAP Free Drug List are fully covered (no deductible)
Mail-Order Purchases	You pay 10% for generic drugs and 20% for brand-name drugs, for up to a 100-day supply

Prescription Drug Benefits for KPIC HAP Members (Administered by KPIC)	
Annual Deductible	ANNUAL DEDUCTIBLE coordinates with medical plan; $1,000/individual, $2,000/family maximum. Deductible applies for all prescription drugs, except for preventive medications and devices on the HAP Free Drug List
Annual Out-of-Pocket Maximum	▪ $2,400 per person, $4,800 per family ▪ Out-of-pocket maximum coordinates with the medical and mental health/substance abuse coverage. Covers both retail drugs and mail-order drugs. Non-covered expenses are not eligible charges and will not count toward your annual deductible or out-of-pocket maximum, nor will these expenses be covered by the Plan after your annual out-of-pocket maximum is met.
Lifetime Maximum	None
Preventive Drugs and Devices	▪ Preventive medications on the HAP Free Drug List are fully covered (no deductible) at either KPIC HAP pharmacies or KPIC mail order ▪ Contraceptive devices (including birth control) indicated on the HAP Free Drug List are considered preventive and are fully covered (no deductible)
Infertility and Sexual Dysfunction Drugs	▪ You pay 50% for both retail and mail-order plans

Generic Incentive Provision – Anthem HAP

For Anthem HAP members, for all prescription drug purchases, whether at a retail drug store or through mail-order, members will be responsible for paying the difference between the price of a generic prescription drug and a brand-name prescription drug, plus coinsurance, if purchasing a brand-name drug when a generic is available. (The difference in cost between the brand-name drug and the generic drug does not apply toward your ANNUAL DEDUCTIBLE or out-of-pocket maximum.) Here's an example of how the "Generic Incentive Provision" works:

Example of a brand-name purchase versus a generic purchase:

Al has single coverage in the HAP and has met his $1,000 deductible for the year. He purchases a 30-day supply of Mevacor, a brand-name prescription drug, at the local pharmacy. He chooses not to use the generic alternative, Lovastatin.

	Generic	Brand-Name
Drug Name and Price	Lovastatin ($24.04)	Mevacor ($79.10)
Coinsurance	$3.61 (15% of $24.04)	$19.78 (25% of $79.10)
Price difference between brand-name and generic	Not applicable	$55.06 ($79.10 - $24.04)
Member's Total Cost	$3.61	$74.84 ($19.78 + $55.06)
Extra cost for member to purchase brand-name drug	$71.23 ($74.84 - $3.61)	

If Al had elected to use the generic alternative, Lovastatin, his coinsurance would have been 15% of the $24.04 price tag of the generic drug, or $3.61. However, because he chooses to purchase the brand-name drug (Mevacor) when a generic is available, his coinsurance will be 25% of the higher price for the brand-name drug, or $19.78. In addition to this coinsurance amount, he must pay the full difference in price between the brand name drug and generic drug ($79.10 - $24.04 = $55.06). In total, Al must pay $74.84 for the brand-name prescription (coinsurance amount of $19.78 plus the brand-generic price difference of $55.06). By purchasing the generic version, Al could have saved $71.23. (Please note that prices shown in this example are for purposes of illustration only. Actual prices will vary.)

For Anthem HAP members, certain brand-name drugs will not be subject to the "pay the difference" penalty. These brand-name drugs are on Express Scripts' Narrow Therapeutic List, which changes from time to time. In addition, if no generic version exists for a brand-name drug, the penalty will not apply. Only the 25% brand coinsurance will apply to the purchase of these brand-name prescription drugs. Your participating pharmacy has Express Scripts' Narrow Therapeutic List and will charge you the correct coinsurance amount.

Step Therapy Provision – Anthem HAP

For Anthem HAP members, the plan has a "Step Therapy Provision." To ensure members have access to clinically appropriate medications, the plan requires that members try generic medication or lower-cost brand-name alternatives first, instead of higher-cost brand-name drugs. Express Scripts will review and approve exceptions if brand-name drugs are required. Members may request such a review by submitting an appeal directly to Express Scripts.

Eligibility

For Anthem HAP members, employees and their Eligible Dependents are eligible for the prescription drug coverage administered by Express Scripts.

For KPIC HAP members, employees and their Eligible Dependents are eligible for prescription drug coverage administered by Kaiser Permanente.

How the Plan Works

For Anthem Blue Cross HAP members

If you are in the Anthem HAP, the Retail Pharmacy Service, managed by Express Scripts, helps you pay part of the cost of retail prescription drugs — that is, drugs that you purchase at local pharmacies.

When you enroll in the Anthem HAP, you are issued a member identification card by Express Scripts. Go to any participating pharmacy, present your card identifying you as an Express Scripts member, and pay the appropriate coinsurance. You may also go to a non-participating pharmacy; however, you will be responsible for paying the entire cost of the prescription upfront and then filing a claim form for reimbursement. It is likely that a non-participating pharmacy will charge more than the pre-NEGOTIATED RATEs of a participating pharmacy. Reimbursement is based on the amount a participating pharmacy would have charged, minus the coinsurance amount. You may call 800-718-6590 or go to www.express-scripts.com to verify pharmacy participation.

Maintenance drugs (i.e., those you use on an ongoing basis) purchased at a participating retail pharmacy will be reimbursed for up to three 30-day supplies at 85% for generic drugs and 75% for brand-name drugs. There is no coverage at retail for refills of maintenance drugs beyond 90 days (three total fills of each prescription). For example, members will pay 15% for an initial 30-day supply of a generic maintenance drug as well as for two 30-day generic refills at a retail pharmacy. If the member requests a fourth prescription of a maintenance drug at a retail pharmacy, the reimbursement rate will drop to 0% and the member has to pay 100% of the cost. Therefore, it is suggested that members use Express Scripts mail-order pharmacy for refills of maintenance drugs beyond a 90-day supply.

Here's how to use mail order for maintenance drugs:

- Ask your PHYSICIAN for two separate prescriptions: one prescription for a 30-day supply (to be filled at your local retail pharmacy) and one prescription for a 90-day supply (to be filled through Express Scripts' mail-order pharmacy).
- Have your 30-day prescription filled immediately at your retail pharmacy. About two weeks later (after you have used up half of your 30-day supply and have decided to continue taking this particular prescription drug), submit your 90-day prescription to Express Scripts' mail-order pharmacy. This will allow a 14-day turn-around time for your mail-order prescription to be delivered to your home. Express Scripts will not issue your 90-day supply if you send your order in any sooner than this because it will still be too early to fill the prescription.

Express Scripts Mail-Order Pharmacy

Express Scripts' mail-order pharmacy is available to employees and their Eligible Dependents who are enrolled in the HAP administered by Anthem Blue Cross.

This program enables you to purchase your maintenance medications, often at a savings, while having them delivered directly to your home via U.S. mail. "Maintenance" medications are those drugs that you take on a long-term or an on-going basis — in other words, those drugs that you know you'll need and can order in advance. Some examples of conditions for which maintenance medications are prescribed are high blood pressure, high cholesterol, heart disorders, diabetes, arthritis and stomach ulcers.

How Express Scripts' Mail-Order Pharmacy Works

With Express Scripts mail-order pharmacy, you may obtain up to a 90-day supply of medication for each prescription. You pay 10% of the cost for each prescription filled with generic drugs, and 20% for those filled with brand-name drugs. If you elect to use a brand-name drug when a generic drug is available, you will be responsible for paying the difference between the price of the generic drug and the brand-name drug, plus coinsurance, as described under Generic Incentive Provision.

Patient Profile

When you order from Express Scripts' mail-order pharmacy for the first time, you will need to complete the last portion of the initial order form, which is a Health Assessment Questionnaire. Complete this form and mail it, along with your original prescription, in an envelope addressed to:

Express Scripts
P.O. Box 747000
Cincinnati, Ohio 45274-7000

The Express Scripts mail-order form, which includes the Health Assessment Questionnaire, and mail-order envelopes are available by calling Express Scripts Member Services at 800-718-6590. You may also download the form from Express Scripts' website at www.express-scripts.com or from the "Forms" page at www.mypgebenefits.com.

The purpose of the Health Assessment Questionnaire is to alert the pharmacists who are filling your prescriptions of any allergies or medical conditions that might be affected by the prescriptions you are ordering, in an effort to prevent any potentially harmful drug reactions. All information in the Health Assessment Questionnaire is confidential.

Paying Your Coinsurance

You can request that Express Scripts bill you for your coinsurance, up to $100, or you can instruct Express Scripts to bill your credit card or debit card (e.g., VISA, MasterCard, or your YSA debit card). Alternatively, you can submit payment in advance. To do so, you will need to call Express Scripts to find out the amount of your coinsurance. Then send your personal check or money order, along with your original prescription, when you send in your order.

Obtaining Your Medications

Express Scripts will mail your medications directly to your home. You will receive your medication within 14 days from the date on which Express Scripts receives your order. If you need your prescription sooner, just let Express Scripts know and, for an extra charge, your prescription will be sent via UPS or Federal Express.

Whenever possible, your prescription will be filled with a generic drug that meets the same standards as the brand name, unless your physician specifies otherwise.

Express Scripts' specialty pharmacy, Accredo Health Group, handles prescriptions for complex conditions such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis, which are treated with specialty medications. Specialty medications are typically injectable medications administered either by yourself or by a health care professional, and often require special handling. In addition, Express Scripts partners with Arriva Medical to fulfill prescription requests for certain drugs and supplies covered by Medicare Part B. For more information about Accredo or Arriva Medical, please call Express Scripts Member Services at 800-718-6590.

Ordering Your Refills

You can order your refills by mail or by calling Express Scripts directly at 800-718-6590, 24 hours a day, seven days a week, except Thanksgiving and Christmas. For refills by mail, send the refill slip provided with your last mail-order prescription, along with your copayment, to Express Scripts, P.O. Box 747000, Cincinnati, Ohio 45274-7000. You may also order your refills online using Express Scripts' website at www.express-scripts.com. You can also check on the status of your refill online.

When Your Current Prescription Expires

Prescriptions expire one year from the date of issue, regardless of whether you have any refills left. You may mail your new prescription to Express Scripts, P.O. Box 747000, Cincinnati, Ohio 45274-7000. You may also have your physician fax your new prescription to Express Scripts. Ask your doctor to call 888-327-9791 for instructions.

For KPIC HAP members

If you are in the KPIC HAP, you must obtain covered drugs, supplies, and supplements from a network pharmacy or through Kaiser Permanente's mail-order service unless the item is covered under emergency services, POST-STABILIZATION CARE, or out-of-area URGENT CARE. See "Emergency, Post-Stabilization, and Out-of-Area Urgent Care Received from Non-Network Providers – KPIC HAP" on page 130.

Refills

You may be able to order refills from a network pharmacy, Kaiser Permanente's mail-order service, or through Kaiser Permanente's website at kp.org/rxrefill. A network pharmacy can give you more information about obtaining refills, including the options available to you for obtaining refills. For example, a few network pharmacies don't dispense refills and not all drugs can be shipped through the mail-order service. Please check with your local network pharmacy if you have a question about whether or not your prescription can be mailed or obtained from a network pharmacy. Items available through the mail-order service are subject to change at any time without notice.

Days' Supply Limit

The prescribing PHYSICIAN or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of days' supply coverage limits, network physicians determine the amount of an item that constitutes a MEDICALLY NECESSARY supply for you.

Upon payment of the cost sharing specified in this ` section, you will receive the supply prescribed up to the days' supply limit also specified in this section. The days' supply limit is either a 30-day supply in a 30-day period or a 100-day supply in a 100-day period. If you wish to receive more than the covered days' supply limit, then you must pay charges for any prescribed quantities that exceed the days' supply limit.

Note: Episodic drugs prescribed for the treatment of sexual dysfunction disorders are covered up to a maximum of 8 doses in any 30-day period or up to 27 doses in any 100-day period.

The pharmacy may reduce the days' supply dispensed at the designated cost sharing to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your network pharmacy can tell you if a drug you take is one of these drugs).

Claims

KPIC is the claims administrator for prescription drug coverage if you enrolled in the KPIC HAP. For information on filing a claim, see "Filing a Claim" on page 201.

What the HAP Covers

Covered expenses under the HAP consist of drugs and medicines approved by the Food and Drug Administration for general use by the public that require a written prescription by a PHYSICIAN and that are dispensed by a licensed pharmacist, physician, or HOSPITAL for take-home purposes. Eligible drugs and medicines include:

Is It Covered?

If you are not sure if a particular drug is covered, contact your HAP prescription drug administrator (Express Scripts at 800-718-6590 or KPIC at 866-427-7701). There are some prescriptions that require PRE-AUTHORIZATION.

- Drugs that require a prescription, except those specifically excluded under "What the HAP Doesn't Cover" on page 151;
- Compound drugs that contain at least one prescription drug;
- Insulin, including hypodermic needles and syringes when insulin is also purchased;
- Over-the-counter diabetic supplies, including items used for daily blood and urine sample testing (except diabetic monitors);
- Retin-A, as MEDICALLY NECESSARY;
- Vitamins that require a prescription;
- Attention Deficit Disorder drugs (e.g., Methylphenidate, Dextroamphetamine, Methamphetamine, Dextroamphetamine/Amphetamine);
- Smoking deterrents that require a prescription (e.g., Habitrol, Nicoderm, and Prostep anti-smoking patches);
- Anorexiants with pre-authorization;
- INFERTILITY, sexual dysfunction, and memory enhancement drugs; and
- Oral contraceptives.

Free Prescriptions

Some prescriptions will be free through your administrator. For Anthem HAP members, free prescription drugs are available only through the Express Scripts mail-order program. For KPIC HAP members, free prescription drugs are available at KPIC network pharmacies and through KPIC's mail-order program. Listed drugs may change periodically; check with Express Scripts or KPIC for updated information, or refer to the appropriate HAP Free Drug List on www.mypgebenefits.com.

Medically Necessary

The HAP only covers services and supplies that are medically necessary. For the purpose of prescription drugs, medically necessary services and supplies are those provided by a hospital, physician or other provider that: (i) have been established as safe and effective; (ii) are furnished in accordance with generally accepted professional standards to treat illness or injury, and are in accordance with the accepted standards of medical practice in the geographic area where the services are provided; (iii) are consistent with the symptoms and diagnosis or treatment of the illness, injury or condition; (iv) are furnished at the most appropriate level that can be provided safely and effectively to the patient; and (v) are not furnished primarily for the convenience of the patient, the attending physician or other provider. Medically necessary prescriptions will be paid at the standard level or rate of coverage.

How New Prescription Drugs Are Added

The HAP covers prescription drugs approved by the Food and Drug Administration (FDA), as long as they are used in the FDA-approved manner, used in accordance with manufacturers' usage guidelines, and approved by the Plan Administrator. Coverage for new prescription drugs will begin upon FDA approval.

What the HAP Does Not Cover

No benefit will be provided for any expense incurred for the following drugs, medicines, substances or supplies rendered, unless specifically listed as a benefit under What the HAP Covers. Ineligible drugs, medicines, substances and supplies include:

- For KPIC HAP members, any drug that is not obtained from a network pharmacy and is not on the formulary list (unless otherwise specified).
- Drugs, medicines, substances or supplies that are not MEDICALLY NECESSARY (see "Medically Necessary Services" on page 128);
- Experimental and investigational drugs;
  - Experimental or investigational drugs are not covered under the HAP. These drugs are typically new products that are still being tested by the FDA and have not been approved for general distribution under the standard prescription process. Further, drugs that are limited by federal law to investigational use and that are labeled as such are not covered. A drug may also be considered experimental if prescribed for an indication or at a dosage that is not an accepted use based on published reports in standard drug publications such as the American HOSPITAL Formulary Service Drug Information and the United States Pharmacopeia Dispensing Information.
- Drugs or supplies that may be dispensed without a prescription;
- Medications not used in accordance with the FDA's approval specifications;
- Inpatient medications (i.e., drugs dispensed or used while you are a patient in a licensed hospital, rest home, sanitarium, extended care facility, SKILLED NURSING FACILITY, convalescent home, nursing home, or similar institution). Inpatient drugs are covered under the medical plan provisions of the HAP.
- Retin-A, unless medically necessary;
- Smoking deterrents other than those listed under What the HAP Covers;
- Allergy serums;
- Therapeutic devices or appliances;
- Drugs prescribed solely for cosmetic purposes (e.g., Renova) or to promote or stimulate hair growth (e.g., Rogaine);
- Immunization agents and vaccines;
- Biologicals, blood, or blood plasma;
- Charges for the administration or injection of a drug;
- Any prescription refill in excess of the number specified by the PHYSICIAN, or any refill after one year from the date of the physician's original order;
- Medications to which you are entitled under any Workers' Compensation or occupational disease law;
- Medication furnished by any other drug or medical service for which no charge is made to the participant; and
- Any drug for which benefits are paid under another Company-sponsored health plan or benefit program.

For further details, see "Reductions/Exclusions for Duplicate Coverage" under "If You Have Other Coverage" in the *Health Care Participation* section.

Coordination of Benefits – Anthem HAP

If you are covered by another plan that has prescription drug coverage that is primary to the Anthem HAP (see "If You Have Other Coverage" in the *Health Care Participation* section), you will need to ensure that the appropriate coordination of benefits forms have been submitted.

If you are an Anthem HAP member, you will need to fill out an Express Scripts Coordination of Benefits/Direct Claim Form in order to receive any secondary benefit, if eligible, from Express Scripts. The form is available by calling Express Scripts Member Services at 800-718-6590. It can also be downloaded from www.express-scripts.com or www.mypgebenefits.com.

You must submit a separate claim form for each pharmacy used and for each patient. You will need to attach documentation to the completed form. The documentation required depends on which plan is primary, as follows:

- If the primary plan is another health plan, you must attach the claim statement, or Explanation of Benefits, that you received from the primary plan to the completed Express Scripts form.
- If the primary plan is an HMO or another plan in which a copayment or coinsurance is paid at the pharmacy, you will need to attach receipts that clearly show the amounts you paid at the pharmacy.
- If the primary plan is another Express Scripts plan, you will need to attach either the prescription receipt or the statement of benefits you received from Express Scripts.

Complete instructions are included on the Express Scripts Coordination of Benefits/Direct Claim Form.

Claims and Appeals

For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Care Plan for Active Employees or to make election changes to your coverage under the Plan, see "Claims and Appeals Process" on page 180 and the *Health Care Participation* section.

For information on how to file a claim for prescription drug coverage, please see "Filing a Claim" under "Claims and Appeals Process - Prescription Drug Benefits" under "Filing a Claim" on page 201.

Glossary

Accidental Injury

Physical harm or disability which is the result of a specific, unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Adverse Benefit Determination:

- A denial, reduction, or termination of a benefit by the Plan, a rescission of coverage by the Plan (as defined in 26 CFR 54.9815-2712T(a)(2), 29 CFR 2590.715-2712(a)(2), and 45 CFR 147.128(a)(2)), or a failure of the Plan to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of your, or your beneficiary's, eligibility to participate in the Plan;
- A denial, reduction, or termination of a benefit by the Plan, or a failure of the Plan to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review; and a failure of the Plan to cover an item or service for which benefits are otherwise provided because such item or service is determined to be experimental or investigational or not Medically Necessary or appropriate.

Ambulatory Surgical Center

A freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

KPIC HAP members must use a Kaiser Permanente Network facility unless otherwise stated in this Handbook.

Annual Deductible

A fixed amount you pay out of pocket each year before the plan begins to pay benefits.

Clinically Stable

You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during, or as a result of, the discharge or transfer.

Effective Date

The date coverage begins under the HAP.

Eligible Expenses

Eligible expenses are: (1) expenses for covered health services that are covered by the Plan; (2) those that Anthem Blue Cross or KPIC considers "medically necessary" for the diagnosis or treatment of an illness or injury; and (3) for Anthem HAP members, those that do not exceed the "reasonable and customary" rate as determined by Anthem Blue Cross or, in the case of services rendered by network providers, the negotiated rate.

Additionally, for KPIC HAP members, eligible expenses are defined as:

- for services provided by Kaiser Permanente, the charge in the relevant Kaiser Foundation Health Plan's schedule of Kaiser Permanente charges for services provided to participants;
- for services that EPO Providers (other than Kaiser Permanente) provide under a contract with Kaiser Permanente, the amount that the provider has agreed to accept as payment in full under that contract;

- for items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge you for the item if your benefits did not cover the item; and
- for all other services, the amounts that Kaiser allows for the services,

Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Anthem Blue Cross Member Services or Kaiser Permanente Customer Service.

Experimental Procedures

Procedures that are mainly limited to laboratory and/or animal research.

Home Health Agencies

Home health care providers that are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Health Care Organizations.

KPIC HAP members must use a Kaiser Permanente Network facility unless otherwise stated in this Handbook.

Hospice

An agency or organization primarily engaged in providing palliative care (pain control and symptom relief) to the terminally ill and providing supportive care to those persons and their families to help them cope with the patient's terminal illness. This care may be provided in the home or on an inpatient basis. A hospice must be: (1) certified by Medicare as a hospice; (2) recognized by Medicare as a hospice demonstration site; or (3) accredited as a hospice by the Joint Commission on Accreditation of Hospitals. A list of hospices meeting these criteria is available upon request by contacting Anthem Blue Cross Member Services or Kaiser Permanente Customer Service.

KPIC HAP members must use a Kaiser Permanente Network facility unless otherwise stated in this Handbook.

Hospital

A facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of physicians. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations. KPIC HAP members must use a Kaiser Permanente Network facility unless otherwise stated in this Handbook.

Infertility

The presence of a condition recognized by a physician as a cause of infertility; or the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Investigative

Procedures or medications that have progressed to limited use on humans but are not widely accepted as proven and effective within the organized medical community.

Medically Necessary

Medically necessary services are those procedures, supplies, equipment or services which your Claims Administrator determines to be:

- Appropriate and necessary for the diagnosis or treatment of the medical condition;
- Provided for the diagnosis or direct care and treatment of the medical condition;

- Within standards of good medical practice within the organized medical community;
- Not primarily for your convenience, or for the convenience of your physician or another provider; and
- The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
  - There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
  - Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
  - For HOSPITAL stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Negotiated Rate

For the Anthem HAP, a negotiated rate is the amount network providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Prudent Buyer Plan Participating Provider Agreements, Exclusive Provider Agreements and/or other Blue Card PPO Provider Agreements.

Network Provider

One of the following providers that has a network agreement in effect with the Claims Administrator at the time services are rendered:

- A hospital;
- A physician;
- An ambulatory surgical center;
- A home health agency;
- A facility that provides diagnostic imaging services;
- A durable medical equipment outlet;
- A skilled nursing facility;
- A clinical laboratory;
- A home infusion provider;
- An urgent care center;
- A retail health clinic;
- A hospice;
- A licensed ambulance company;
- A licensed qualified autism service provider.

Network providers agree to accept the negotiated rate as payment for covered services. A directory of network providers is available upon request by contacting Anthem Blue Cross Member Services or Kaiser Permanente Customer Service.

Non-Network Provider

Any provider that does not have a network agreement in place with the Claims Administrator, including:

- A hospital;
- A physician;
- An ambulatory surgical center;
- A home health agency;
- A facility that provides diagnostic imaging services;
- A durable medical equipment outlet;
- A skilled nursing facility;
- A clinical laboratory;
- A home infusion therapy provider;
- An urgent care center;
- A retail health clinic;
- A hospice;
- A licensed ambulance company
- A licensed qualified autism service provider

For Anthem HAP members, only a portion of the amount which a non-network provider charges for a service may be treated as a covered expense. For KPIC HAP members, non-emergency services received from a non-network provider or facility are covered only for authorized referrals, emergencies and out-of-area urgent care. For details, see "Emergency, Post-Stabilization, and Out-of-Area Urgent Care Received from Non-Network Providers – KPIC HAP" on page 130.

Other Health Care Provider

One of the following providers:

- A certified registered nurse anesthetist;
- A blood bank.

The provider must be licensed to provide covered medical services according to state and local laws.

Physician

- A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
- One of the following providers, but only when the provider is licensed to practice where the care is provided; the provider is rendering a service within the scope of that license; the provider is providing a service for which benefits are specified in this booklet; and benefits would be payable if the services were provided by a physician:
  - A dentist (D.D.S.)
  - An optometrist (O.D.)
  - A dispensing optician
  - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
  - A licensed clinical psychologist

- A licensed educational psychologist for the provision of behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
- A chiropractor (D.C.)
- An acupuncturist (A.C.)
- A licensed clinical social worker (L.C.S.W.)
- A marriage and family therapist (M.F.T.)

Services obtained from the following providers are covered only by referral of a PHYSICIAN as defined in the first bullet above:

- A physical therapist (P.T. or R.P.T.)
- A speech pathologist
- An audiologist
- An occupational therapist (O.T.R.)
- A licensed professional clinical counselor (L.P.C.C.)
- A respiratory care practitioner (R.C.P.)
- A psychiatric mental health nurse (R.N.)
- A nurse midwife (for Anthem Blue Cross HAP members only)
- A registered dietitian (R.D.) for the provision of covered medical nutrition therapy only

Post-Stabilization Care

Post-stabilization care is medically necessary services related to your emergency medical condition that you receive after your treating physician determines that your emergency medical condition is clinically stable.

Pre-Authorization

Approval obtained in advance required for some covered services. Pre-authorization is not a guarantee of payment under the Plan; all services must be medically necessary for reimbursement.

Region

A geographic region serviced by Kaiser Permanente. Each region contains service areas that cover a smaller geographic area.

Service Area

For the KPIC HAP, a service area is a smaller geographic area (county or portion of a county) of a Kaiser Permanente Region.

Skilled Nursing Facility

An institution that provides continuous skilled nursing services. The facility must be licensed according to state and local laws and must be recognized as a skilled nursing facility under Medicare.

KPIC HAP members must use a Kaiser Permanente network facility unless otherwise stated in this Handbook.

Special Care Units

Special areas of a hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Stay

Inpatient confinement that begins when you are admitted to a facility and ends when you are discharged from that facility.

Urgent Care

The services received for a sudden, serious, or unexpected illness, injury or condition, other than one that is life threatening, which require immediate care for the relief of severe pain or diagnosis and treatment of the condition.

Claims and Appeals Process

For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Account Plan for Active Employees or to make election changes to your coverage under the Plan, see the *Health Care Participation* section.

Claims and Appeals — Medical Benefits

Your medical plan claims administrator depends on whether you're enrolled in the Anthem HAP or the KPIC HAP.

- **If you're in the Anthem HAP**: Anthem Blue Cross, on behalf of Anthem Blue Cross Life & Health Insurance Company (referred to as "Anthem Blue Cross" or "Anthem" in this document), is your claims administrator. For Anthem HAP members, the information contained in this "Claims and Appeals – Medical Benefits" section applies to claims for medical expenses only.
- **If you're in the KPIC HAP**: Kaiser Permanente Insurance Company (referred to as "KPIC" in this document) is your claims administrator. For KPIC HAP members, the information contained in this "Claims and Appeals – Medical Benefits" section applies to claims for medical, mental health and substance abuse, and prescription drug benefits administered by KPIC.

Filing a Claim

Anthem HAP

- NETWORK PROVIDERS: When you receive care from a network provider, the network provider is responsible for submitting claims on your behalf, and Anthem Blue Cross pays the network provider directly for your covered health services. You are responsible for paying coinsurance and/or deductibles to the network provider once your claim is processed and you have received a bill from the provider. If the network provider bills you for a portion of any covered health services that the plan should have covered, contact Anthem Blue Cross at 800-964-0530.
- NON-NETWORK PROVIDERS: When you receive care from a non-network provider, you are responsible for paying the provider up front for your covered health services and filing a claim with Anthem Blue Cross, even if your services were due to an emergency or if your network provider referred you to a non-network provider. Your claim for payment of benefits must include all information required to process the claim, in a format acceptable to Anthem Blue Cross.

  You can obtain a claim form by calling Anthem Blue Cross at 800-964-0530. You can also download a claim form at www.anthem.com/ca/pge or www.mypgebenefits.com.

  If a non-network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If your claim relates to an inpatient HOSPITAL STAY, the date of service is the date on which your inpatient stay ends.

  All claims for payment of benefits must be filed within **one year plus 90 days** of the date of service. If your claim isn't filed by this deadline, benefits for that health service will be denied. This time limit does not apply if you are legally incapacitated.

KPIC HAP

- Network Providers: When you receive care from a network provider, the provider is responsible for submitting claims on your behalf, and KPIC, on behalf of the Plan Sponsor, pays the provider directly for your covered health services. If a network provider bills you for a portion of any covered services (other than for cost sharing) that the Plan should have covered, please call Kaiser Permanente Customer Service.

- Non-Network Providers: When you receive eligible services from a non-network provider, and the provider has agreed to submit a claim on your behalf, eligible claims payment to the provider will require a valid assignment of benefits.

  If you have paid for eligible expenses, your claim (or letter) requesting reimbursement, and all information necessary to process the claim, must be mailed to KPIC within two years of the date of service for medical claims, or within one year for prescription drugs — except for controlled substances which have a six month claims filing limit.

  To obtain a medical claim form, go to the Kaiser Permanente website, www.my.kp.org/ca/pge:

  - log in with your user name and password;
  - go to "My Health Manager," then "My Medical Record."

  You may also download Kaiser claim forms for medical and prescription drug expenses at www.mypgebenefits.com.

Contact Kaiser Permanente Customer Service (800-663-1771 for the Northern California REGION and 800-533-1833 for the Southern California Region) if:

- a network provider bills you for a portion of any covered services (other than for cost sharing) that the plan should have covered; or
- you have any questions about submitting a claim for services received from a non-network provider.

Required Information for the Anthem and KPIC HAP

When you request payment of benefits from Anthem Blue Cross or KPIC, you must provide as part of your claim all of the following information:

- the member's name and address;
- the patient's name, age, and relationship to the member;
- the member identification number and group or health record number stated on your Anthem Blue Cross or Kaiser Permanente ID card;
- an itemized bill from your provider that includes the following:
  - patient diagnosis;
  - date(s) of service;
  - procedure code(s) and description of service(s) rendered;
  - charge for each service rendered; and
  - provider name, address, and Tax Identification Number (TIN)
- the date on which the injury or sickness began; and
- a statement indicating whether or not you are enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name(s) of the other carrier(s).

Send your claim to:

If you're in the Anthem HAP	If you're in the KPIC HAP
Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	KPIC Self-Funded Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547 Payor ID # 94320

Language Assistance

Anthem Blue Cross and KPIC provide certain written translation and oral interpretation services to members with limited English proficiency. Written materials available for translation include appeal letters, consent forms, claim denial letters, and explanations of benefits (EOBs). Language assistance resources are provided to you at no additional cost.

If you're in the Anthem HAP

Written materials are available in the following languages:

- Spanish
- Chinese
- Vietnamese
- Korean
- Navajo
- Tagalog

Oral interpretation services are available in additional languages.

To request written materials or oral interpretation services, contact Anthem Blue Cross customer service by calling the phone number on your ID card to update your language preference, to receive future translated documents, or to request interpretation assistance.

If you're in the KPIC HAP

Written or oral interpretation services are available in the following languages:

- Spanish
- Chinese
- Navajo
- Tagalog

To request written materials or oral interpretation services, call 877-261-6608

- Spanish (Español): Para obtener asistencia en Español, llame al 877-261-6608
- Chinese: (中文): 如果需要中文的帮助,请拨打这个号码 877-261-6608
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 877-261-6608
- Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-261-6608

Payment of Benefits for Non-Network Benefits – Anthem Blue Cross

Anthem Blue Cross will make a benefit determination on non-network services. Benefits will be paid directly to you, unless either of the following is true:

- The provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to that provider; or
- You make a written request for the NON-NETWORK PROVIDER to be paid directly at the time you submit your claim.

Anthem Blue Cross will not reimburse third parties who have purchased or who have been assigned benefits from physicians or other providers.

Benefit Determinations (Before an Appeal Is Filed)

There are various types of benefit claims. Each benefit claim can be categorized as a post-service, pre-service, urgent, or concurrent claim. Depending on the type of the claim, Anthem Blue Cross or KPIC must process your claim within different time frames. The processing time frames for each type of claim are explained in this section.

Post-Service Claims

Post-service claims are those claims that are filed for payment of benefits after medical care has been received. The plan will pay you directly for covered post-service claims, unless:

- you have assigned your right to payment to the provider; or
- your claim includes a written request that the plan pay the provider.

If your post-service claim is denied, Anthem Blue Cross or KPIC will send you a written response in the form of an Explanation of Benefits (EOB) within 30 days of receipt of the claim, provided that all required information was included with the claim. The claims administrator will notify you within this 30-day period if additional information is needed to process your claim, and may request a one-time extension of no longer than 15 days and pend your claim until all required information is received.

If notified that an extension is necessary due to incomplete claim information, you will have 45 days to provide the required information to Anthem Blue Cross or KPIC. If all of the required information is received within the 45-day time-frame and the claim is then denied, Anthem Blue Cross or KPIC will notify you of the denial within 15 days of receipt of the additional information. If you do not provide the needed information within the 45-day period, your claim will be denied.

If your claim is denied, the denial notice – typically an Explanation of Benefits statement – will explain the reason(s) for the denial, refer to the Plan provision(s) on which the denial is based, and provide procedures on how to appeal the claim.

Pre-Service Claims

Pre-service claims are those claims for services that require notification or approval prior to receiving the services. Requests for pre-service claims that are not urgent may be requested by the NETWORK PROVIDER by calling Anthem Blue Cross at 800-274-7767, or Kaiser Permanente Customer Service at 800-663-1771 for the Northern California REGION or 800-533-1833 for the Southern California Region.

Or you can submit your claim in writing:

If you're in the Anthem HAP	If you're in the KPIC HAP
Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	KPIC Self-Funded Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547 Payor ID # 94320

If your claim is a pre-service claim and was submitted properly with all the required information, Anthem Blue Cross or KPIC will send you and your network provider written notice of its claim decision within 15 days of receipt of the claim. If you file a pre-service claim improperly, Anthem Blue Cross or KPIC will notify you and the network provider that the claim was improperly filed within five days of receiving the pre-service claim and will give you information on how to correct it. If additional information is needed to process the pre-service claim, Anthem Blue Cross or KPIC will notify you within 15 days of receipt of the claim that additional information is needed, and may request a one-time extension of no longer than 15 days and pend your claim until all required information is received.

If notification of an extension is necessary due to incomplete claim information, you will have 45 days to provide the required information to Anthem Blue Cross or KPIC. If all of the required information is received within the 45-day time-frame, Anthem Blue Cross or KPIC will notify you of its determination within 15 days of receipt of the additional information. If you don't provide the required information within the 45-day period, your claim will be denied.

If your claim is denied, the denial notice will explain the reason(s) for the denial, refer to the Plan provision(s) on which the denial is based, and provide procedures on how to appeal the claim.

Urgent Claims that Require Immediate Action

URGENT CARE claims are those claims (1) that require notification or approval prior to receiving medical care, and (2) where a delay in treatment could jeopardize your life, health, or the ability to regain maximum function, could cause serious impairment to bodily function or serious dysfunction for any body organ or part or, in the opinion of a PHYSICIAN with knowledge of your medical condition, could cause severe pain. In these situations, where your claim is considered as urgent, you or your network provider may call Anthem Blue Cross at 800-274-7767, or Kaiser Permanente Customer Service at 800-663-1771 for the Northern California Region or 800-533-1833 for the Southern California Region.

Or you can submit your urgent claim in writing:

If you're in the Anthem HAP	If you're in the KPIC HAP
Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	KPIC Self-Funded Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547 Payor ID # 94320

After the claims administrator receives the request, you will receive a response as follows:

- You and your network provider will receive notice of the claim determination in writing or by telephone within 72 hours of Anthem Blue Cross' or KPIC's receipt of all necessary information, taking into account the seriousness of your condition. Notice of denial may be oral with a written confirmation to follow within three days.
- If you file an urgent care claim improperly, Anthem Blue Cross or KPIC will notify you or your network provider within 24 hours of receiving the urgent claim that the claim was improperly filed and will give you information on how to correct it. If additional information is needed to process the claim, Anthem Blue Cross or KPIC will notify you or your network provider of the information needed within 24 hours of receiving the claim. You will have 48 hours to provide the requested information.

You and your network provider will be notified of Anthem Blue Cross' or KPIC's determination no later than 48 hours after:

- Anthem Blue Cross' or KPIC's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that timeframe.

If your claim is denied, the notice of the denial will explain the reason(s) for the denial, refer to the Plan provision(s) on which the denial is based, and provide procedures on how to appeal the claim.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you or your network provider requests to extend the treatment as an urgent care claim, Anthem Blue Cross or KPIC will make a determination on your request within 24 hours of receiving your request, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and handled according to the described time-frames.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you or your network provider requests to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service time-frames, whichever applies.

Concurrent claims that are considered urgent may be submitted by calling Anthem Blue Cross at 800-274-7767, or Kaiser Permanente Customer Services at 800-663-1771 for the Northern California Region or 800-533-1833 for the Southern California Region.

Or you can submit your urgent or non-urgent claim in writing:

If you're in the Anthem HAP	If you're in the KPIC HAP
Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	KPIC Self-Funded Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547 Payor ID # 94320

To Resolve a Problem

If You're in the Anthem HAP

Anthem Blue Cross has established a complaint resolution and appeal process to resolve members' problems or complaints. If you or a covered dependent has a question, problem, or complaint, you should call 800-964-0530 or write to the following address:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

If your question or concern is about a benefit determination, you should typically contact Member Services before filing a formal appeal. If the Member Services representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing or file an appeal. If you wish to file an appeal, you should contact Customer Service again and state that you would like to file an appeal. You may also send your written appeal to Anthem Blue Cross at the following address:

Anthem Blue Cross
P.O. Box 4310
Woodland Hills, CA 91365-4310

If you are appealing a pre-service URGENT CARE claim denial, please refer to Urgent Claims that Require Immediate Action, earlier in this section, and contact Member Services at 800-964-0530 immediately. The Member Services telephone number is also shown on your ID card. Member Services representatives are available to take your call during posted business hours, Monday through Friday.

If You're in the KPIC HAP

You can lodge a service complaint. Here are some examples of reasons why you might lodge a complaint:

- You are not satisfied with the quality of care you received.
- You are dissatisfied with how long it took to get services, including getting an appointment, in the waiting room, or in the exam room.
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility.

If you have a question, problem or complaint, you can discuss your concerns with the Customer Service representatives at most facilities, or you can call Kaiser Permanente Customer Service at the number on your ID card. You may also appoint an authorized representative to help you file your complaint. A written authorization must be received from you before any information will be communicated to your representative.

Your problem or complaint must explain your concern, such as why you are dissatisfied with services received and this complaint must be submitted within 180 days of the date of the incident that caused your dissatisfaction. You can submit your complaint:

- at Kaiser Permanente facilities (please refer to your welcome book for addresses);
- by calling the Customer Service Call Center at the number on the back of your ID card; or
- by going to the Customer Service website, www.my.kp.org/ca/pge, and submitting your complaint online.

You will receive a confirmation letter within five days after receipt of your complaint, and a written decision within 30 days after receipt of your complaint. Note: If your issue is resolved to your satisfaction by the end of the next business day after your complaint is received orally or through the website, and a Customer Service representative notifies you orally about the decision, you will not receive a confirmation letter or a written decision.

If Your Claim Is Denied

If your claim for benefits is denied or if your coverage is rescinded, you will receive an adverse benefit determination. You are entitled to a full and fair review of the adverse benefit determination.

If your claim is denied, the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the claims administrator's determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- a statement that diagnostic and treatment codes are available upon request;
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- the claims administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- the claims administrator may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

The notice will also state how and when to request a review of the denied claim.

If applicable, the notice will also contain a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination following completion of all levels of review.

Your Right to Appeal

If you disagree with a claim determination after following the steps for filing a claim, you can file an appeal of an adverse benefit determination with Anthem Blue Cross or KPIC. Your appeal must be filed within 180 days of receiving the adverse benefit determination.

Appeals Process

Anthem Blue Cross and KPIC provide two levels of appeal for each claim: a first-level appeal and a second-level appeal. At each appeal level, a qualified individual who was not involved in an earlier denial of your claim will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be conducted by a health care professional who has appropriate expertise in the specific clinical area and who was not involved in any prior denial determination. Anthem Blue Cross or KPIC may consult with or seek the participation of medical experts as part of the appeal resolution process. For certain claims, using both the first and second levels of appeals to your claims administrator is required. For others, it is not.

Further Review of Claims Involving Medical Judgments or Rescissions of Coverage

If you are not satisfied with the claim and appeal decisions of Anthem Blue Cross or KPIC and your claim involves medical judgment or a rescission of coverage, you have the right to an External Review by an Independent Review Organization. For details regarding External Review, see "Your Right to External Review by an Independent Review Organization (IRO)" on page 189.

First-Level Appeals

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly jeopardize your life, health or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- Your appeal does not need to be submitted in writing. You or your PHYSICIAN should call Anthem Blue Cross at 800-274-7767, or Kaiser Permanente Customer Service (800-663-1771 for the Northern California REGION or 800-533-1833 for the Southern California Region).
- Anthem Blue Cross or KPIC will provide you with a written or oral determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

Second-level appeals of urgent claims are not required. However, if you wish to initiate a second appeal, you must follow the same steps as outlined below under "Non-Urgent Claim Appeals." Your second-level appeal must be submitted to Anthem Blue Cross or KPIC within 60 days of your receipt of the first-level appeal decision. Again, a second-level appeal for urgent claims is not required for you to proceed with an External Review by an Independent Review Organization or file a lawsuit. For details regarding External Review, see "Your Right to External Review by an Independent Review Organization (IRO)" on page 189.

Non-Urgent Claim Appeals

You or your authorized representative must contact Anthem Blue Cross or KPIC in writing to formally appeal the claim denial or adverse benefit determination. If the appeal relates to a claim for payment, your request should include:

- the patient's name and the identification number from your ID card;
- the date(s) of medical service(s);
- the provider's name;
- the reason you believe the claim should be paid; and
- any document or other written information to support your request for claim payment.

You may request, at no cost, to have access to and copies of all documents, records, and other information relevant to your claims for benefits. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the adverse claim determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan and applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

Send your appeal to:

If you're in the Anthem HAP	If you're in the KPIC HAP
Anthem Blue Cross ATTN: Appeals P.O. Box 4310 Woodland Hills, CA 91365-4310	For medical claims appeals: Kaiser Permanente Insurance Company (KPIC) – Appeals 3701 Boardman-Canfield Road Canfield, Ohio 44406 Fax: 614-212-7110 For post- or pre-service pharmacy claims appeals: Kaiser Permanente Insurance Company (KPIC) Attn: SFES National Self Funding 3840 Murphy Canyon Road San Diego, CA 92123 Fax: 858-614-7912

Your first level request to appeal the claim must be submitted to Anthem Blue Cross or KPIC within 180 days of your receipt of the claim denial.

First-Level Appeals Determination

Anthem Blue Cross or KPIC will review all information that you or your authorized representative submits in support of your claim appeal, regardless of whether the information was submitted or considered during the initial adverse claim determination. If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not MEDICALLY NECESSARY, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

If new or additional evidence is considered, relied upon, or generated in connection with your claims, Anthem Blue Cross or KPIC will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse claim determination on review based on a new or additional rationale, the claims administrator will provide you, free of charge, with the rationale and with an opportunity to respond to the new or additional rationale.

Responses to Pre-Service and Post-Service First-Level Appeals

You and your NETWORK PROVIDER will be provided written notification of Anthem Blue Cross' or KPIC 's decision on your first-level appeal as follows:

For appeals of pre-service claims, Anthem Blue Cross or KPIC will conduct the first-level review and notify you of its decision within 15 days of receipt of your request to appeal the denied claim.

For appeals of post-service claims, Anthem Blue Cross or KPIC will conduct the first-level review and notify you of its decision within 30 days of receipt of your request to appeal the denied claim.

Please note that Anthem Blue Cross' or KPIC 's decision is based only on whether or not benefits are covered health services, as defined by the HAP. The determination as to whether the health service is necessary or appropriate is between you and your physician.

Second-Level Appeals

If you are dissatisfied with the Plan's first-level appeal decision, you may file a second-level appeal. Second-level appeals to Anthem Blue Cross or KPIC for pre-service claims are voluntary. However, for post-service claims you are required to submit a second-level appeal to Anthem Blue Cross or KPIC before you can request an External Review by an Independent Review Organization or file a lawsuit (see below.) The second level of appeal will be conducted by an appropriate reviewer who did not make the initial determination or decide the first-level appeal and who does not work for the person who made the initial determination or first-level appeal determination.

If you would like to initiate a second-level appeal, please write to the address below. Second-level appeals must be submitted within 60 calendar days of the date on which your first-level appeal is denied. If you're in the KPIC HAP, you may also fax your appeal:

If you're in the Anthem HAP	If you're in the KPIC HAP
Anthem Blue Cross ATTN: Appeals P.O. Box 4310 Woodland Hills, CA 91365-4310	Kaiser Permanente Insurance Company (KPIC) – Appeals 3701 Boardman-Canfield Road Canfield, Ohio 44406 Fax: 614-212-7110

With respect to post-service claims, you must complete a first- and second-level appeal prior to submitting a request for an independent External Review or filing a lawsuit.

With respect to pre-service claims and URGENT CARE claims, you must complete a first-level appeal prior to submitting a request for an independent External Review or filing a lawsuit.

For details regarding External Review, see "Your Right to External Review by an Independent Review Organization (IRO)" below.

Responses to Second-Level Appeals

You and your provider will be provided written notification of Anthem Blue Cross' or KPIC's decision on your second-level appeal as follows:

- For appeals of pre-service claims, Anthem Blue Cross or KPIC will notify you of its decision within 30 days of receipt of your request for a second-level appeal review.
- For appeals of post-service claims, Anthem Blue Cross or KPIC will notify you of its decision within 30 days of receipt of your request for a second-level appeal review.

Please note that Anthem Blue Cross' or KPIC's decision is based only on whether or not benefits are covered health services, as defined by the medical plan. The determination as to whether the health service is necessary or appropriate is between you and your physician.

Your Right to External Review by an Independent Review Organization (IRO)

If the outcome of all mandatory appeals is adverse to you, you can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of filing a civil action with respect to your claim under Section 502(a) of ERISA. To be eligible for independent external review, your claim must involve medical judgment or a rescission of coverage. Also to be eligible for independent external review, generally, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal to both the plan and request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

Requesting External Review

To file for an independent external review, Anthem or KPIC, as applicable, must receive your external review request within four months of the date of the adverse benefit determination. (If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline is the next business day.) Submit your request to:

If you're in the Anthem HAP	If you're in the KPIC HAP
Anthem Blue Cross ATTN: Appeals P.O. Box 4310 Woodland Hills, CA 91365-4310	Complete the External Review request form on www.my.kp.org/ca/pge and mail or fax it to: Kaiser Permanente Insurance Company (KPIC) – Appeals 3701 Boardman-Canfield Road Canfield, OH 44406 Fax: 614-212-7110

Expedited External Review

If you submit an urgent external review request, the Plan will immediately determine if you are eligible for an urgent external review. Urgent processing will be granted if, in the judgment of the Plan, the application of the time periods for making non-URGENT CARE determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. If you are eligible for urgent processing, the Plan will immediately determine if you are eligible for an external review and send you a letter notifying you whether your request for external review has been approved.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO. The IRO will notify you in writing that the request for an external review was received. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 72 hours and send you and Anthem or KPIC, as applicable, written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a).

All Other Review Requests

If you submit an external review request, the Plan will review, within five business days, your claim to determine if you are eligible for external review, and within one business day of its decision, send you a letter notifying you whether your request has been approved for external review.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO within five business days. The IRO will notify you in writing that it has received the request for an external review. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 45 calendar days and send you and Anthem or KPIC, as applicable, written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a).

Your Claim After External Review

You may have certain additional rights if you remain dissatisfied after you have exhausted all levels of review including external review. Since you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 866-444-EBSA (3272). In addition, states with Consumer Assistance Programs under PHS Act Section 2793 may be available in your state for assistance.

A list of the state Consumer Assistance Programs is available at www.dol.gov/ebsa/capupdatelist.doc.

Reversal of the HAP Claims Administrator's Decision

The IRO's decision is binding on the Plan but not on you. Upon receipt of a notice of a final external decision reversing the adverse benefit determination or final internal adverse benefit determination, the HAP claims administrator will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

PG&E Voluntary Claims and Appeals Review Process

If you are not satisfied with the claims and appeals review process completed with Anthem or KPIC, you may elect to use PG&E's Voluntary Claims and Appeals Review Process (for all claims other than those relating to medical judgment or rescission of coverage), as described below, or elect to bring a civil action. You have 90 days from the date of receipt of the final decision from Anthem or KPIC to elect this claims and appeals review process. Initiation of the Voluntary Review Process does not restrict your ability to bring a civil action against the Plan. For claims relating to medical judgment or rescission of coverage, you should use the External Review process described in the preceding section.

The first step of the Voluntary Claims and Appeals Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include a HIPAA AUTHORIZATION TO USE AND/OR DISCLOSE PERSONAL HEALTH INFORMATION form. You can access a copy online from the Human Resources Forms section of the PG&E@Work intranet or by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Send your appeal to:

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

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the HIPAA Authorization form may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial;
- a reference to the Plan provision(s) which apply to the denial; and
- an explanation of additional appeals procedures.

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

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

Benefits for an ongoing course of treatment will not be reduced or terminated while an appeal is pending. However, if the appeal is denied in whole or in part, you may be financially responsible for the cost of the denied portion.

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

- the specific reason(s) for the denial;
- 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.

Binding Arbitration for the KPIC HAP

Scope of Arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- the claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to a Participant or Dependent Party's relationship to KPIC or KPIC as a Participant or Dependent, a member, or a patient, including any claim for medical or HOSPITAL malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the delivery of services or items, irrespective of the legal theories upon which the claim is asserted;
- the claim is asserted by one or more Participant or Dependent Parties against one or more KPIC Parties or by one or more KPIC Parties against one or more Participant or Dependent Parties;
- the claim is *not* within the jurisdiction of the Small Claims Court; and
- the claim is *not* a benefit-related request that constitutes a "benefit claim" in Section 502(a)(1)(B) of ERISA.

As referred to in this "Binding Arbitration for the KPIC HAP" section, a "Participant" or "Dependent Parties" include:

- a Participant or Dependent;
- a Participant's or Dependent's heir, relative, or personal representative; and
- any person claiming that a duty to him or her arises from a Participant's or Dependent's relationship to one or more KPIC Parties

"KPIC Parties" include:

- Kaiser Permanente Insurance Company (KPIC);
- Kaiser Foundation Health Plan, Inc.;
- Kaiser Foundation Hospitals (KFH);
- KP Cal, LLC (KP Cal);
- The Permanente Medical Group, Inc. (TPMG);
- Southern California Permanente Medical Group (SCPMG);
- The Permanente Federation, LLC;
- The Permanente Company, LLC;
- any KFH, TPMG, or SCPMG PHYSICIAN;
- any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Participant or Dependent Parties; or
- any employee or agent of any of the foregoing

"Claimant" refers to a Participant or Dependent Party or a KPIC Party who asserts a claim as described above. "Respondent" refers to a Participant or Dependent Party or a KPIC Party against whom a claim is asserted.

Initiating Arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include all claims against Respondents that are based on the same incident, transaction, or related circumstances in the Demand for Arbitration.

Serving Demand for Arbitration

Kaiser Permanente Insurance Company (KPIC), Kaiser Foundation Health Plan, Inc., KFH, KP Cal, TPMG, SCPMG, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of one of the following:

- If the claim relates to a Participant or Dependent who is assigned to the Kaiser Permanente Northern California REGION:

  Kaiser Foundation Health Plan, Inc.
  Legal Department
  1950 Franklin St., 17th Floor
  Oakland, CA 94612

- If the claim relates to a Participant or Dependent who is assigned to the Kaiser Permanente Southern California Region:

  Kaiser Foundation Health Plan, Inc.
  Legal Department
  393 E. Walnut St.
  Pasadena, CA 91188

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing Fee

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling Customer Service at the telephone number listed on your ID card.

Number of Arbitrators

The number of Arbitrators may affect the Claimant's responsibility for paying the neutral arbitrator's fees and expenses.

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of Arbitrators' Fees and Expenses

Kaiser Foundation Health Plan, Inc. will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* (Rules of Procedure). In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration for the KPIC HAP" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

Rules of Procedure

Arbitrations shall be conducted according to the Rules of Procedure developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Customer Service.

General Provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration for the KPIC HAP" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration for the KPIC HAP" section.

In accord with the rule that applies under sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration for the KPIC HAP" section shall not be denied, stayed, or otherwise impeded because a dispute between a Participant or Dependent Party and a KPIC Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Arbitration Agreement for Participants and Dependents Assigned to the Kaiser Permanente Northern California Region or Southern California Region

I understand that if I am assigned to the Kaiser Permanente Northern California Region or Southern California Region, then except for Small Claims Court cases, cases subject to a Medicare appeals procedure, and certain benefit-related disputes, any dispute between myself, my heirs or relatives, or other associated parties on the one hand and Kaiser Permanente Parties on the other hand (Kaiser Permanente Insurance Company, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, The Permanente Medical Group, the Southern California Permanente Medical Group, or other associated parties), for alleged violation of any duty relating to or arising from a relationship to any of the Kaiser Permanente Parties as a participant in this medical plan, a member, or a patient, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the delivery of services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the summary plan description.

Claims and Appeal Process — Mental Health and Substance Abuse Benefits

If You're in the Anthem HAP

ValueOptions is the claims administrator for mental health and substance abuse benefits. As the claims administrator, ValueOptions contracts with a network of providers and facilities and processes claims for services.

If You're in the KPIC HAP

For the following benefits...	The claims administrator is...
Inpatient and Alternate Levels of Care for Mental Health	KPIC
Outpatient Mental Health	
Detoxification, Inpatient and Residential Levels of Substance Abuse	ValueOptions
MEDICALLY NECESSARY Outpatient Substance Abuse	KPIC
Structured Outpatient, Partial Hospitalization and Outpatient Substance Abuse	
Autism Applied Behavior Analysis	ValueOptions or KPIC, as applicable

Filing a Claim

If your mental health and substance abuse benefits are administered by KPIC, please see "Filing a Claim" on page 180 for details on the claims filing process.

If your mental health and substance abuse benefits are administered by ValueOptions, the claims filing process is as follows:

- NETWORK PROVIDERS: When you receive services from a network provider or facility, the provider will send the claim directly to ValueOptions for payment.

- NON-NETWORK PROVIDERS: When you receive services from a non-network provider or facility, and a provider has agreed to submit a claim on your behalf, eligible claims payment to the provider will require a valid assignment of benefits.

  If you have paid for services, your claim (or letter) requesting reimbursement, and all information necessary to process the claim, must be submitted to ValueOptions.

All claims must be made within two years of the date on which services or supplies were received. Claim forms are available by calling ValueOptions at 800-562-3588.

Inquiries, Benefit Certifications, and Claims

Many problems, complaints or potential claim issues can be resolved informally. In fact, most requests for services and inquiries can be handled over the telephone.

If your mental health and substance abuse benefits are administered by KPIC, please see "To Resolve a Problem" on page 185 to receive assistance with questions, issues, or complaints.

If your mental health and substance abuse benefits are administered by ValueOptions, contact ValueOptions at 800-562-3588 to:

- receive assistance with questions, issues, or complaints;
- find a NETWORK PROVIDER; or
- receive a benefits certification, which is a pre-approval of coverage for services.

Generally, a determination of your benefit request will be made by the end of the telephone conversation and will be confirmed with a written notification from ValueOptions. If the benefit certification cannot be made at the time of the phone call, you will receive a written notification from ValueOptions of the decision. The type of benefit certification requested will determine the timeframe for the receipt of notification.

The processing timeframes for receipt of benefit certifications are as follows:

- URGENT CARE — where a delay in treatment could jeopardize your life or health — within 72 hours of receipt of your request.
- **Non-urgent —** a request for services that require PRE-AUTHORIZATION — within fifteen calendar days of receipt of your request.
- **Concurrent care —** a request for continuation of current treatment — within one day for urgent requests, fifteen calendar days for non-urgent requests.

For urgent care and urgent concurrent care certifications, notification by telephone will be made to your provider at the time of the determination, along with written notification to you and your provider.

Your Right to Appeal

If your mental health and substance abuse benefits are administered by KPIC, please see "To Resolve a Problem" on page 185" for details on appeals.

If your mental health and substance abuse benefits are administered by ValueOptions, the claims appeals process is as follows:

If you disagree with a claim determination after following the steps for filing a claim, you can file an appeal of an adverse benefit determination with ValueOptions. Your appeal must be filed within 180 days of receiving the adverse benefit determination.

Appeals Process

Pre-Service Appeals — Non-Urgent

If you are not satisfied with ValueOptions' initial determination or benefit certification resolution or you believe you have received some other type of adverse benefit determination that is preventing you from receiving the services you requested in the process of trying to obtain a benefits certification, you can appeal the benefit denial/determination within 180 days of receipt of the denial or adverse determination. Your appeal may be made in writing or by calling ValueOptions at 800-562-3588. If you submit your appeal in writing, you must include the following information: your name, member ID, phone number, the service for which benefit coverage has been denied, and any additional information that may be relevant to your appeal. The appeal should be sent to:

ValueOptions
Attention: Appeals
P.O. Box 6065
Cypress, CA 90630-0065

ValueOptions will mail you a decision notice within 15 calendar days of receipt of your appeal. The notice will include the specific reason(s) for the decision and the Plan provision(s) on which the decision was based. You have the right to receive, upon request only and at no charge, the information used by ValueOptions to review your appeal.

If you are not satisfied with ValueOptions' decision, you have 90 days from the date of your receipt of the decision notice to request a second level of appeal. To initiate a second level of appeal, you can submit the appeal in writing by sending it to the ValueOptions address above or you can call ValueOptions at 800-562-3588. A professional committee composed of two or more members who were not involved in the initial decision will conduct the review. The decision regarding your request will be sent to you within 15 calendar days of its receipt by ValueOptions. If at this point your appeal is denied, you can bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

Pre-Service Appeals — Urgent

If your appeal for coverage involves URGENT CARE, you can request an expedited review by telephoning or writing to ValueOptions. You will be notified of the benefit determination within 72 hours of ValueOptions' receipt of the appeal. A Medical Department representative will contact your provider to schedule a time for a telephone review of your case. Your provider will be advised of the determination at the end of the telephone review. A written notification of the decision will be sent to you and your provider within three calendar days of the verbal notification. If you or your provider has additional information to be included in the appeal, you will need to provide the additional information within three days of the appeal request.

An urgent appeal is any claim for treatment with respect to which the application of the time periods for a non-urgent care determination could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function or, in the opinion of a PHYSICIAN with knowledge of the claimant's medical condition, could subject the claimant to severe pain that cannot be adequately managed.

If you receive an adverse benefit determination on your appeal, you have the right to further appeal the decision. You have 90 days to request a second level of appeal. A professional committee composed of two or more members, or a board-certified MD Peer Advisor, who was not involved in the initial decision, will conduct the review. A benefit determination will be sent to you and your provider within 15 calendar days of your request. You may submit the appeal in writing or by calling ValueOptions at 800-562-3588.

Written appeals should be sent to:

ValueOptions
Attention: Appeals
P.O. Box 6065
Cypress, CA 90630-0065

If at this point your appeal is denied, you can bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

Post-Service Appeals

If you believe that your claims were processed or denied incorrectly, you can try to resolve the issue informally as described under "Inquiries, Benefit Certifications, and Claims" on page 196. If this approach is unsatisfactory, you may appeal the initial claim determination. To initiate an appeal, you must write or telephone ValueOptions (800-562-3588) within 180 days of receipt of the claim processing determination. Your appeal must include the following information: your name, member ID, phone number, a copy of the denied or incorrectly processed claim and any additional information that may be relevant to your appeal. Written appeals should be sent to:

ValueOptions
Attention: Appeals
P.O. Box 6065
Cypress, CA 90630-0065

A decision notice will be mailed to you within 30 days of receipt of your appeal by ValueOptions. The notice will include the specific reason(s) for the decision and a reference to the Plan provision(s) on which the decision was based. You also have the right to receive, only upon request and at no charge, the information that ValueOptions used to review your appeal. If the information you submit with your appeal is incomplete, you will be notified by letter of the additional information needed. If you do not send the information within 45 days of the date on which you received the letter, an administrative denial may be issued.

If at this point your appeal is denied, you can bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

Submitting an Appeal

You must submit your appeal within 180 calendar days following receipt of an adverse determination notice, or following any incident or action that is the subject of your dissatisfaction. Appeals may be filed telephonically, in person, in writing, by facsimile, by e-mail or online through the ValueOptions website, www.valueoptions.com. ValueOptions will mail an appeal form to you for this purpose, and a copy of ValueOptions' Appeals Procedure, upon request. If you wish, ValueOptions' Member Services staff will assist in completing the Appeal form. Completed Appeal forms must be mailed to ValueOptions at P.O. Box 6065, Cypress, California, 90630-0065. ValueOptions will acknowledge receipt of an appeal within five calendar days of receipt of the Appeal.

Expedited Review for Urgent Appeals

You have the right to an expedited review for urgent appeals involving an imminent and serious threat to the health of the Member, including but not limited to severe pain, potential loss of life, limb, or major bodily functions. The request may be initiated by you, your authorized representative, or by your provider. Call ValueOptions at 888-445-4436 and tell the representative that you are requesting an expedited review of an urgent appeal. ValueOptions will notify the provider of the decision in no more than 72 hours and send the Member a written statement on the disposition or pending status of the appeal within the same 72 hours from receipt of the appeal.

Your Right to External Review by an Independent Review Organization (IRO)

For mental health and substance abuse benefits administered by KPIC, please see "Your Right to External Review by an Independent Review Organization (IRO)" on page 189.

If the outcome of all mandatory appeals is adverse to you, you can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of filing a civil action with respect to your claim under Section 502(a) of ERISA. To be eligible for independent external review, your claim must involve medical judgment or a rescission of coverage. Also to be eligible for independent external review, generally, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal to both the plan and request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

Requesting External Review

To file for an independent external review, ValueOptions must receive your external review request within four months of the date of the adverse benefit determination. (If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline is the next business day.) Submit your request to:

ValueOptions®
Attn: National PA Services, External Review
12369-C Sunrise Valley Drive
Reston, VA 20191

Fax for expedited requests: 877-826-8584

Expedited External Review

If you submit an urgent external review request, the Plan will immediately determine if you are eligible for an urgent external review. Urgent processing will be granted if, in the judgment of the Plan, the application of the time periods for making non-URGENT CARE determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. If you are eligible for urgent processing, the Plan will immediately determine if you are eligible for an external review and send you a letter notifying you whether your request for external review has been approved.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO. The IRO will notify you in writing that the request for an external review was received. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 72 hours and send you and ValueOptions written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a).

All Other Review Requests

Once you have submitted your external review request, the Plan will review, within five business days, your claim to determine if you are eligible for external review, and within one business day of its decision, send you a letter notifying you whether your request has been approved for external review.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO within five business days. The IRO will notify you in writing that it has received the request for an external review. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 45 calendar days and send you and ValueOptions written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a).

Your Claim After External Review

You may have certain additional rights if you remain dissatisfied after you have exhausted all levels of review including external review. Since you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 866-444-EBSA (3272). In addition, states with Consumer Assistance Programs under PHS Act Section 2793 may be available in your state for assistance.

A list of the state Consumer Assistance Programs is available at www.dol.gov/ebsa/capupdatelist.doc.

Reversal of the HAP Claims Administrator's Decision

The IRO's decision is binding on the Plan, but not on you. Upon receipt of a notice of a final external decision reversing the adverse benefit determination or final internal adverse benefit determination, the HAP claims administrator will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

PG&E Voluntary Claims and Appeals Review Process

If you are not satisfied with the claims and appeals review process completed with ValueOptions or KPIC, you may elect to use PG&E's Voluntary Claims and Appeals Review Process (for all claims other than those relating to medical judgment or rescission of coverage), as described below, or elect to bring a civil action. You have 90 days from the date of receipt of the final decision from ValueOptions or KPIC to elect this claims and review process. Initiation of the Voluntary Review Process does not restrict your ability to bring a civil action against the Plan. For claims relating to medical judgment or rescission of coverage, you should use the External Review process described in the preceding section.

The first step of the Voluntary Claims and Appeals Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include a HIPAA AUTHORIZATION TO USE AND/OR DISCLOSE PERSONAL HEALTH INFORMATION form. You can access a copy online from the Human Resources Forms section of the PG&E@Work intranet or by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973- 4357 or toll-free at 800-788-2363.

Send your appeal to:

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

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the HIPAA Authorization form may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial;
- a reference to the Plan provision(s) which apply to the denial; and
- an explanation of additional appeals procedures.

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

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

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

- the specific reason(s) for the denial;
- 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.

Claims and Appeals — Prescription Drug Benefits

If you're in the Anthem HAP	If you're in the KPIC HAP
Express Scripts is the claims administrator for prescription drug benefits.	KPIC is the claims administrator for prescription drug benefits.

Filing a Claim

For prescription drug benefits administered by KPIC, please see "Filing a Claim" on page 180 for details on the claims filing process.

For prescription drug benefits administered by Express Scripts, the claims filing process is as follows:

- Participating Retail Pharmacies: When you receive services from a participating retail pharmacy, simply present your Express Scripts identification card and pay the appropriate coinsurance. There are no claim forms to file.
- Non-Participating Pharmacies: You will be responsible for paying the full cost of the prescription to the pharmacist, and then filing a claim for reimbursement. Claim forms are available by calling Express Scripts at 800-718-6590 or at Express Scripts' website, www.express-scripts.com. If you are a first-time visitor to the website, you'll need to register as a user. Please remember to have your member ID number and a recent prescription number handy when you register. Claim forms can also be obtained at www.mypgebenefits.com.

In accordance with federal law, all claims for prescription drugs, except controlled substances, must be made within 12 months of the date on which the prescription was written by the PHYSICIAN. If you do not file a claim within this timeframe, your claim will be denied. Federal law also requires that all claims for controlled substances must be made within six months of the date on which the prescription was written by the physician.

Other Circumstances When Claim Forms Are Required

There are other circumstances that require you to pay the full cost of your prescription and file a claim form for reimbursement with Express Scripts. These include:

- Purchasing drugs at a participating pharmacy without presenting your Express Scripts identification card (reimbursement will be limited to the cost for the drug negotiated by Express Scripts and the pharmacy; any additional amounts charged to you by the pharmacy will be your responsibility); or
- Having other prescription drug coverage pay benefits first, with Express Scripts serving as secondary payor on any claim remainder. This is called a Coordination of Benefits or "COB" claim; see "If You Have Other Coverage" in the *Health Care Participation* section.

Language Assistance

If you need assistance understanding information about your prescription drug coverage in a language other than English, foreign language assistance may be available to you.

For verbal and, if eligible, written assistance in the following languages, please call 800-753-2851:

- Spanish (Español): Para obtener asistencia en Español, llame al 800-753-2851
- Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-753-2851
- Chinese: (中文): 如果需要中文的帮助,请拨打这个号码 800-753-2851
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-753-2851

Benefit Determinations (Before an Appeal Is Filed)

There are various types of benefit claims. Each benefit claim can be categorized as a post-service, pre-service, or urgent claim. Depending on the type of the claim, Express Scripts must process your claim within different time frames. The processing time frames for each type of claim are explained in this section.

Post-Service Claims

Post-service claims are those claims that are filed for payment of benefits after services have been received. If your post-service claim was submitted properly with all the required information, Express Scripts will send you written notice of its claim decision not later than 30 days after receipt of the claim. If you file a post-service claim improperly, Express Scripts will notify you that the claim was improperly filed within 30 days of receiving the post-service claim and will give you information on how to correct it. If additional information is needed to process the post-service claim, you will have 45 days to provide the information. If all of the needed information is received within the 45-day time frame, Express Scripts will notify you of its determination not later than 15 days after the later of receipt of the information or the end of that additional time period. If you don't provide the required information within the 45-day period, your claim will be denied and you have the right to appeal.

Pre-Service Claims

Pre-service claims are those claims for services that require notification or approval prior to receiving the services. If your claim is a pre-service claim and was submitted properly with all the required information, Express Scripts will send you written notice of its claim decision not later than 15 days after receipt of the claim. If you file a pre-service claim improperly, Express Scripts will notify you that the claim was improperly filed within 15 days of receiving the pre-service claim and will give you information on how to correct it. If additional information is needed to process the pre-service claim, you will have 45 days to provide the information. If all of the needed information is received within the 45-day time frame, Express Scripts will notify you of its determination within 15 days of receipt of the additional information. If you don't provide the required information within the 45-day period, your claim will be denied and you have the right to appeal.

If your claim is denied, the denial notice will explain the reason(s) for the denial, refer to the Plan provision(s) on which the denial is based, and provide procedures on how to appeal the claim.

Urgent Claims that Require Immediate Action

An URGENT CARE claim is defined as a request for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 24 hours of receipt of the claim. If you receive an adverse determination on your claim, you will be provided with a written statement that explains the denial and includes instructions on how to appeal that decision.

If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your claim is considered denied and you have the right to appeal.

To Resolve a Problem

If you have an issue or complaint regarding your prescription drug benefits, you should first address your concerns with the claims administrator (Express Scripts or KPIC, as applicable).

For prescription drug benefits administered by KPIC, please see "To Resolve a Problem" on page 185 for assistance with questions, issues, or complaints.

For prescription drug benefits administered by Express Scripts, refer to the information in this section.

Contact Express Scripts within 60 days after the issue or complaint arises. Many problems, complaints, and potential claim issues can be resolved informally. You can address these informal complaints by phoning Express Scripts at 800-718-6590. Express Scripts may ask you to provide additional information or ask your PHYSICIAN to do so, or may try to clarify any information already provided. Express Scripts will research your issue and respond to you on its findings either in writing or by telephone within 15 days for prescriptions that have not been filled, and within 30 days for prescriptions that have already been filled and paid.

Your Right to Appeal

For prescription drug benefits administered by KPIC, please see "Claims and Appeals Process" on page 180 for details on appeals.

For prescription drug benefits administered by Express Scripts, refer to the information in this section.

If you disagree with a claim determination after following the steps for filing a claim, you can file an appeal of an adverse benefit determination with Express Scripts. Your appeal must be filed within 180 days of receiving the adverse benefit determination.

Appeals Process

Express Scripts provides two levels of appeal for each claim: a first-level appeal and a second-level appeal.

First-Level Appeals

Non-Urgent Appeal

If you are not satisfied with the decision regarding your benefit coverage or you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered denied because missing information was not timely submitted), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of the notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your PHYSICIAN). To initiate an appeal for coverage, provide in writing:

- your name;
- member ID;
- phone number;
- the prescription drug for which benefit coverage has been denied;
- the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes); and
- any additional information that may be relevant to your appeal.

This information should be mailed to:

Express Scripts
Attention: Appeals
P.O. Box 631850
Irving, TX 75063-0030

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request for pre-service claims or within 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any, considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes, contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes, and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal.

Urgent Claim Appeals that Require Immediate Action

In the case of a claim for coverage involving URGENT CARE, you will be notified of the benefit determination within 24 hours of receipt of the claim. If you receive an adverse determination on your claim, you will be provided with a written statement that explains the denial and includes instructions on how to appeal that decision.

An urgent care claim is defined as a request for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your claim is considered denied and you have the right to appeal as described below.

Second-Level Appeal

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of receipt of the notice of the decision, a second level appeal. A second-level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second-level appeal, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and
- any additional information that may be relevant to your appeal.

This information should be mailed to:

Express Scripts
Attention: Appeals
P.O. Box 631850
Irving, TX 75063-0030

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or within 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any, considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes, contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes, and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second-level appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your second-level appeal, such information will be provided to you together with an opportunity to respond prior to issuance of any final adverse determination of this appeal. The decision made on your second-level appeal is final and binding.

If your second-level appeal is denied and you are not satisfied with the decision of the second-level appeal (i.e., your "final adverse benefit determination"), you also have the right to bring a civil action under ERISA section 502(a) and/or to submit your claim for review by an external review organization. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. External reviews are not available for decisions relating to eligibility.

Your Right to External Review by an Independent Review Organization (IRO)

For prescription drug benefits administered by KPIC, please see "Claims and Appeals Process" on page 180 for details on your right to external review.

If the outcome of all mandatory appeals is adverse to you, you can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. To be eligible for independent external review, your claim must involve medical judgment or a rescission of coverage. Also to be eligible for independent external review, generally, you must exhaust the internal plan claim review process described above, or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal to both the plan and request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

Requesting External Review

To file for an independent external review, Express Scripts must receive your external review request within four months of the date of the adverse benefit determination. (If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline is the next business day.) Submit your request to:

Express Scripts
Attention: External Review Requests
P.O. Box 631850
Irving, TX 75063-0030

Phone: 800-753-2851
Fax: 888-235-8551

Expedited External Review

If you submit an urgent external review request, the Plan will immediately determine if you are eligible for an urgent external review. Urgent processing will be granted if, in the judgment of the Plan, the application of the time periods for making non-URGENT CARE determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. If you are eligible for urgent processing, the Plan will immediately determine if you are eligible for an external review and send you a letter notifying you whether your request for external review has been approved.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO. The IRO will notify you in writing that the request for an external review was received. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 72 hours and send you and Express Scripts written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a).

All Other Review Requests

If you submit an external review request, the Plan will review, within five business days, your claim to determine if you are eligible for external review, and within one business day of its decision, send you a letter notifying you whether your request has been approved for external review.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO within five business days. The IRO will notify you in writing that it has received the request for an external review. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 45 calendar days and send you and Express Scripts written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a).

Your Claim After External Review

You may have certain additional rights if you remain dissatisfied after you have exhausted all levels of review including external review. Since you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 866-444-EBSA (3272). In addition, states with Consumer Assistance Programs under PHS Act Section 2793 may be available in your state for assistance.

A list of the state Consumer Assistance Programs is available at www.dol.gov/ebsa/capupdatelist.doc.

Reversal of the HAP Claims Administrator's Decision

The IRO's decision is binding on the Plan, but not on you. Upon receipt of a notice of a final external decision reversing the adverse benefit determination or final internal adverse benefit determination, the HAP claims administrator will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

PG&E Voluntary Claims and Appeals Review Process

If you are not satisfied with the claims and appeals review process completed with Express Scripts or KPIC, you may elect to use PG&E's Voluntary Claims and Appeals Review Process (for all claims other than those relating to medical judgment or rescission of coverage), as described below, or elect to bring a civil action. You have 90 days from the date of receipt of the final decision from Express Scripts or KPIC to elect this claims and review process. Initiation of the Voluntary Review Process does not restrict your ability to bring a civil action against the Plan. For claims relating to medical judgment or rescission of coverage, you should use the External Review process described in the preceding section.

The first step of the Voluntary Claims and Appeals Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include a HIPAA AUTHORIZATION TO USE AND/OR DISCLOSE PERSONAL HEALTH INFORMATION form. You can access a copy online from the Human Resources Forms section of the PG&E@Work intranet or by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Send your appeal to:

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

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the HIPAA Authorization form may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial;
- a reference to the Plan provision(s) which apply to the denial; and
- an explanation of additional appeals procedures.

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

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

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

- the specific reason(s) for the denial;
- 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.

Wellness Program

The Pacific Gas and Electric Company, and PG&E Corporation and its covered affiliates (referred to collectively as the "Company" in this section) partner with Provant Health Solutions — a nationally accredited, independent health and wellness company— to offer a wellness program. The program helps you and your family to improve your health through education, tools and resources designed to facilitate health and overall well-being.

In This Section

Eligibility

All active union-represented employees and their spouses or domestic partners are eligible to participate in the Wellness Program. However, only employees enrolled in the Health Account Plan (HAP) will earn incentive credits for health screenings and tobacco-free testing and only employees are eligible to participate in the health screening and tobacco-free testing.

Wellness Program at a Glance

Provant's resources include:

- **health advocacy services** to help you navigate the health care system;
- **health screenings on-site** at larger PG&E locations as well as at home, so you can conveniently check key health indicators like your cholesterol, blood pressure and blood sugar;
- **telephonic health coaching**, which offers one-on-one support to help you meet your health goals;
- a confidential, **online health risk questionnaire**, which offers personalized recommendations on how to best maintain or improve your health;
- an **extensive online health and wellness portal** available 24/7, featuring calorie trackers, meal and exercise plans and much more;
- **a telephonic tobacco cessation program** providing one-on-one support with a certified tobacco cessation specialist; and
- **gym discounts** for you and your family members.

Health Advocacy Services

Provant's team of advocates can help you identify, navigate and resolve a variety of health care matters, including claims or billing issues. For example:

- **Navigational Advocates** can help you find in-network providers and access the care you need.
- **Administrative Advocates** can help with claims paperwork, such as explaining claim payments or resolving billing issues.

These experienced professionals can:

- educate you about PG&E's benefits and help you make informed decisions about coverage;
- help you find the right doctors and health care facilities;
- facilitate authorizations and provider referrals;
- resolve eligibility issues and negotiate with providers;
- help resolve billing and claims issues; and
- assist with grievances and appeals.

You can access advocate services Monday through Friday, 5 a.m. to 5 p.m. Pacific time, at 866-271-8144. You will also be able to gain access to advocates via email at PGESupport@provanthealth.com.

Health Screenings

The Wellness Program covers annual health screenings for employees to identify risk factors that can lead to chronic disease and set health goals that can help delay or prevent these conditions. Screenings also include a test to verify if you are tobacco-free.

Earn Additional Health Account Credits

You can earn additional Health Account Credits by participating in a health screening ($250 for single coverage, $500 for family coverage) and test tobacco free or complete PG&E's tobacco cessation program ($250 for single coverage, $500 for family coverage).

You have three options of locations for completing a health screening:

- **On-site at larger PG&E locations:** Specific locations and dates will be determined and communicated annually. The onsite health screening consists of a non-fasting finger prick to measure total cholesterol, HDL, LDL, LDL/HDL risk ratio and glucose. Body mass index (BMI), height, weight and blood pressure measurements will also be taken.
- **At your health care provider:** If you complete a health screening at your provider's office, you will need to download a Health Screening Results form from Provant's Health & Wellness portal. Your provider must complete the form with results from the past six months or order a wellness screening for new results, then submit the form to Provant. Note that a health screening at your health care provider does not include the tobacco screening, which can only be conducted onsite at PG&E or via the concierge service option.
- **Via a concierge service:** You can contact Provant to schedule a health screening (including the tobacco screening) for your home or for small groups at your work location. Screenings must be scheduled at least two weeks in advance and will be confirmed 24 hours prior. Results for health screenings conducted through the concierge service will not be immediately available. You'll be able to access your results online at **https://pge.provantonline.com** two to three weeks after your screening.

Telephonic Health Coaching

Provant offers telephonic health coaching — professional support to help you reach your personal health goals and enhance your well-being. To participate in health coaching, simply call Provant.

During your initial call, Provant will schedule your first telephonic appointment with a health coach. During your first call with the health coach, your coach will help you develop a Health Action Plan and determine the number of coaching sessions needed to achieve your goals. However, you have unlimited access to your health coach if you desire more frequent contact.

Working together with your health coach, you will:

- better understand your health risks and how they affect your life;
- get answers to pressing health concerns and issues;
- build skills to gain better control over your health and the day-to-day decisions and choices that affect it; and
- set goals and design a customized plan to reach your personal best health.

Provant health coaches are available: Monday through Friday, 5 a.m. to 5 p.m., Pacific time. Coaching appointments can be scheduled from 5 a.m. to 7 p.m. Pacific time. As needed, your health coach will also provide you with tools, guidance and information on how to access Provant programs and services to support your journey to better health. If you are uncomfortable talking to a health coach over the phone, you can go to **https://pge.provantonline.com** to set up a **secure messaging appointment**.

Online Health Risk Questionnaire

The Wellness Program includes an online Health Risk Questionnaire, a secure online 15-minute survey that asks about your current health, diet, fitness, safety and general lifestyle.

Participating in a Health Risk Questionnaire can help you identify life-threatening risk factors which can lead to chronic illness. And because your Health Screening results are pre-populated in the online Health Risk Questionnaire, your survey results can offer you and your health coach the "big picture" on your overall health risks, needs and issues, so you can work together to make lifestyle changes or seek treatment in time to avoid serious illness.

To take the Provant Health Risk Questionnaire, log in to the Health & Wellness portal at **https://pge.provantonline.com** and complete the registration if you haven't already. After you have logged in, on the left side, find the "Health" heading and click on "Health Assessment."

Once you have completed the Health Risk Questionnaire, you will immediately receive your **confidential personal outcomes report** with active links to portal tools and features to help you address any health risks you may have. The report will also generate an individualized wellness plan and action steps and recommendations for making positive lifestyle changes and reducing health risks.

Health & Wellness Portal

Provant's Health & Wellness portal offers a variety of tools and trackers available whenever you have time. Anything you view, participate in or enter into the portal is completely confidential.

- wellness workshops: week-by-week guided programs on a variety of health topics designed to provide you with the means to establish and maintain healthy habits; and
- health tools, including:
  - meal planners that create a customized shopping list based on your health risks and generate a downloadable list that can be taken to the market;
  - exercise planners, created by Provant Health's professional trainers, that offer a weekly regimen of cardiovascular and strength training exercises that you can incorporate into your fitness plan;
  - daily food logs to help you track your meals and analyze your daily nutrition;
  - physical activity logs, such as Strength Training Log, Cardio Log and Pedometer Tracker to help you plan and track your progress toward your fitness goals;
  - a health library and health calculators to help you become better informed about important health topics, such as your target heart rate, recommended daily calcium intake and ideal body mass index (BMI);
  - the "Ask the Dietitian" and "Ask the Trainer" tools that let you submit questions to experts in nutrition and exercise; typical response times are within 24-48 hours; and
  - the Health Risk Questionnaire to help you identify any health risks and create a personalized plan to help you on your path to better health or to maintain your current good health.

To access the Health & Wellness portal, go to: **https://pge.provantonline.com**.

Under "First Time Users" in the bottom right, go to "Click Here to Sign Up." Fill out the registration form to get your user name and password.

Tobacco Cessation Program

PG&E feels that it is important to reward those who have chosen not to use tobacco, and provide support to help current tobacco users end their habit. To help you towards a tobacco-free life, we offer a five-week telephonic or online tobacco cessation program through Provant at no cost to you. You must complete the Tobacco Cessation Program in order to receive your tobacco-free incentive if you test positive for nicotine during your health screening,

The program is designed to help you:

- understand the tobacco habit and nicotine addiction;
- identify smoking/tobacco usage triggers and readiness to quit; and
- learn techniques for becoming and staying tobacco free.

Gym Discounts

You and your family can save on gym memberships through the International Fitness Club Network, (IFCN). IFCN partners with nearly 14,000 health clubs around the world to offer participants:

- the lowest membership fee for the type of membership selected;
- free, one-week trial memberships (subject to space availability); and
- access to quality health clubs that adhere to the American College of Sports Medicine's (ACSM) and International Health, Racquet & Sportsclub Association's (IHRSA) Health and Safety standards.

In addition to providing health club membership discounts, IFCN offers:

- preferred pricing on home fitness equipment (10% discount on NordicTrack fitness equipment at Sears);
- self-paced walking programs; and
- discounts on self-help wellness programs, including smoking cessation, weight loss and stress management.

Employee Assistance Program (EAP)

PG&E's Employee Assistance Program (EAP), administered by ValueOptions, provides professional counseling, consultation and referrals to help you manage life's demands. The EAP is available 24 hours a day, seven days a week at no cost to you and your Eligible Dependents. Use of the program is completely voluntary.

In This Section

EAP Coverage at a Glance

The following chart summarizes the EAP's services:

Employee Assistance Program (EAP)	▪ The EAP provides assistance with issues such as: ▫ Family and relationship problems ▫ Workplace concerns ▫ Alcohol and drug issues ▫ Depression and anxiety ▫ Stress at home or work ▫ Financial and legal concerns ▫ Child and adult care referrals ▪ Services include: ▫ Up to six sessions per six-month period with a licensed EAP counselor ▫ A 30-minute telephonic consultation with a certified financial advisor ▫ A 30-minute telephonic or in-person consultation with an attorney ▫ Work/Life information and referrals to community-based services for child care, adult care, adoption and more ▫ Interactive online tools and resources available from work or home For more information about legal or financial consultations or referrals, see "Legal/Financial Solutions: Value Options" and "Work Life Program" in the *Work/Life Benefits* section.

Eligibility and Cost

EAP benefits are available to all active Company employees, their spouses/registered domestic partners, and their Eligible Dependents. You do not need to be enrolled in the HAP to be eligible for EAP services.

You and your spouse/registered domestic partner and dependents are not eligible for EAP benefits if you are a contract or agency worker, a hiring hall employee or a retired employee.

Cost

There is no charge to you for EAP benefits. If additional help beyond six EAP counseling sessions is needed, you will be referred to your health plan administrator if you are enrolled in the HAP, or to resources in your community if you are not enrolled in the HAP.

Charges for additional services, if any, are your responsibility. Mental health or substance abuse treatment is covered by the HAP when you or your Eligible Dependents are enrolled. You will be responsible for any costs not covered by your health care plan(s).

Confidentiality

The EAP upholds strict confidentiality standards. When you or your family member participates in any EAP service, your involvement is treated confidentially in accordance with all state and federal laws, and company policy. Your EAP counselor will discuss confidentiality during the first session, and give you a Statement of Understanding that explains the EAP's policy in detail.

Circumstances Limiting Confidentiality

The EAP Statement of Understanding outlines conditions and circumstances limiting confidentiality. If you feel you cannot accept the limitations and cannot sign the Statement of Understanding, you will not be eligible to receive services through the EAP. You may, however, be able to receive benefits through your health plan.

Following is a summary of the limits to EAP confidentiality. Please note that some conditions and circumstances apply only to employees and not to dependents. Confidentiality will be limited in the following situations:

- If there is a reasonable basis to suspect child or elder abuse and/or neglect; and to the extent required by state or federal law.
- If in the EAP Counselor's clinical judgment, you pose a serious danger to yourself, others, company property, or public safety.
- If you report information concerning dangerous or illegal activity in the workplace.
- If you or your representative claim alleged wrongdoing by PG&E and/or ValueOptions that you believe has caused you physical, mental, or emotional injury or damage in any threatened or actual lawsuit, arbitration, or administrative proceeding.
- If, during any of your counseling sessions, you suggest you may seek a "reasonable accommodation" under the Americans with Disabilities Act (ADA), a referral may be made to the Accommodations unit, if such disclosure does not conflict with HIPAA; other federal or California confidentiality requirements concerning personal health or substance abuse problems; or treatment. The ADA requires employers to make reasonable accommodation for the known physical or mental limitations of a qualified worker unless the accommodation poses an undue hardship on the employer.
- If you report to EAP any possible violation of PG&E's Equal Employment Opportunity policy, EAP will disclose any complaint of violation to PG&E's Human Resources. (It is actually your responsibility as a PG&E employee to report to Human Resources all complaints of employment discrimination including sexual harassment. All such reports are promptly investigated by PG&E.)
- If release of information is compelled by law, or is needed in an emergency by medical personnel for your diagnosis or treatment and you are unable to authorize disclosure.
- If you were formally referred to EAP by your supervisor, he or she will be notified only as to whether or not you have followed through in contacting EAP. Your supervisor will not be given clinical information.
- In connection with an audit of records by PG&E or its designated auditor to monitor quality and volume of services provided by ValueOptions; however, your identity will not be disclosed to other non-EAP PG&E personnel.

In addition, disclosures may be made in connection with an internal or external audit to monitor quality of service without disclosing your identity to other Company personnel.

Also note that if you were referred to EAP by your supervisor, certain non-clinical information may be disclosed to your supervisor. See "Supervisory Referrals" under "Referrals" on page 218 for more information.

How to Use the Program

If, as an employee, you are located in or near San Francisco, Sacramento, San Jose, Oakland, Stockton, Fresno, Concord, Chico, or at the Diablo Canyon Power Plant, you may contact your local on-site EAP counselor directly. You may also call the toll-free EAP number at 888-445-4436 to obtain a referral to an EAP counselor with an office near your work or home. For the most current list of onsite EAP office locations, call the toll-free EAP number or visit the Employee Assistance Program (EAP) section of the PG&E@Work intranet site. If you are located outside the geographic areas with an onsite EAP counselor, call the toll-free number and a counselor will make an initial assessment of your situation and offer to arrange a face-to-face counseling session with a licensed counselor near your home or work. You can call the toll-free number 24 hours a day, 365 days a year.

Referrals

Self-Referrals

An employee who self-initiates contact with an EAP counselor does not need to tell his or her supervisor. With the employee's consent, the counselor may contact the supervisor to arrange time off from work, but will not provide information about the employee's personal problems.

Supervisory Referrals

If you are having performance problems on the job, your supervisor may make a formal recommendation that you talk with an EAP counselor. If you choose to speak with a counselor, the counselor will not discuss your personal problems with your supervisor. However, if you sign the Statement of Understanding, which is required for you to pursue EAP services, your counselor will provide your supervisor with non-clinical information, such as whether or not you have followed through in contacting EAP. Whether or not you choose to use the EAP or comply with a formal supervisor referral to EAP, you are still responsible for maintaining your job performance.

Referrals to Non-Contracted Providers

Referrals to service providers outside of ValueOptions EAP may be recommended to help you resolve problems. Those services may or may not be covered under your PG&E-sponsored health care plan or that of another employer or insurer through which you may have coverage. A referral, however, is not a guarantee that your medical plan or other provider will cover such services. It is your responsibility to determine whether or not outside services are covered under any such plan and to pay any charges that are not covered. If a referral is made to an outside counselor under your health plan, you are encouraged to follow your health plan's procedures for obtaining proper authorization and encouraged to follow through with any authorized treatment plan.

Leaves of Absence

In the event your EAP counselor recommends a medical leave of absence for you, you are still required to notify your supervisor and complete all required paperwork.

Claims and Appeals Process

For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Care Plan for Active Employees or to make election changes to your coverage under the Program, see the *Health Care Participation* section.

Filing a Claim

Since there is no cost to program participants for EAP services, there are no claims to file for reimbursement.

Appeal Procedures

ValueOptions has an Appeal procedure for receiving and resolving Members' or Providers' Appeals. An Appeal may be submitted up to 180 calendar days following receipt of an adverse determination notice, or following any incident or action that is the subject of the Member's dissatisfaction.

Appeals may be filed telephonically, in person, in writing, by facsimile, by e-mail or online through the ValueOptions Internet site.

ValueOptions will mail an Appeal form for this purpose, and a copy of ValueOptions' Appeals Procedure, to the Member upon request. If the Member wishes, ValueOptions' Member Services staff will assist in completing the Appeal form. Completed Appeal forms must be mailed to:

ValueOptions
P.O. Box 6065
Cypress, California, 90630-0065.
888-445-4436
www.valueoptions.com

ValueOptions will acknowledge receipt of an Appeal within five (5) calendar days of receipt of the Appeal, and will respond in writing with a resolution to an appeal within thirty (30) calendar days of receipt of the Appeal.

Urgent Appeals

You have the right to an expedited review for urgent Appeals involving an imminent and serious threat to the health of the Member, including but not limited to severe pain, potential loss of life, limb, or major bodily functions. The request may be initiated by you, your authorized representative, or by your provider. Call ValueOptions at 888-445-4436 and tell the representative that you are requesting an expedited review of an urgent Appeal. ValueOptions will notify the provider of the decision in no more than 72 hours and send the Member a written statement on the disposition or pending status of the Appeal within the same 72 hours from receipt of the Appeal.

Additional Review

If the Member is not satisfied with ValueOptions' response to an Appeal, the Member may submit a request to ValueOptions for voluntary mediation or binding arbitration within sixty (60) days of receipt of ValueOptions response. However, in the case of binding arbitration, if the Member has legitimate health or other reasons which would prevent the Member from electing binding arbitration within sixty (60) days, the Member may have as long as reasonably necessary to accommodate special needs in order to elect binding arbitration. The Member may file an Appeal with the Department of Managed Health Care after completing the ValueOptions Appeal Process or voluntary mediation or after participating in the ValueOptions Appeal Process or voluntary mediation for thirty (30) days. Further, if the Member seeks review by the Department of Managed Health Care within sixty (60) days of ValueOptions' response, the Member will have an additional sixty (60) days from the date of final resolution by the Department of Managed Health Care to request binding arbitration. Arbitration will be conducted in accordance with the Arbitration section of this EOC.

Voluntary Mediation

In the event a Member is dissatisfied with the ValueOptions' determination, the Member may request voluntary mediation with ValueOptions prior to exercising the right to submit the Appeal to the Department of Managed Health Care. The request must be made within sixty (60) days of the ValueOptions determination. The use of mediation services does not preclude the right to submit the Appeal to the Department of Managed Health Care upon completion of mediation. In order to initiate voluntary mediation, either the Member or an individual acting on the Member's behalf must submit a written request to ValueOptions. If all parties mutually agree to mediation, the mediation will be administered by the Judicial and Mediations Services (JAMS) in accordance with the JAMS Comprehensive Arbitration Rules and Procedures, unless the parties agree otherwise. The expense of mediation shall be shared equally by the parties. The Department of Managed Health Care will have no administrative or enforcement responsibilities with respect to the voluntary mediation process.

Arbitration

Any claim arising under the Employee Assistance Program Agreement, excluding claims involving allegations of medical malpractice, must be submitted to binding arbitration following an attempt at resolution through ValueOptions' Appeal Procedure or Voluntary Mediation if the claim is for monetary damages that exceed the jurisdictional limits of the Small Claims Court. Either the Member, the Employer or ValueOptions may commence arbitration by serving a demand for arbitration on the other. Arbitration will be conducted under the commercial rules of the American Arbitration Association (AAA) then in effect, using a mutually selected attorney arbitrator. If

the parties are unable to select a neutral arbitrator within thirty (30) days after service of a written demand requesting the designation, then a court of competent jurisdiction, on petition of a party to the arbitration, shall appoint the arbitrator as follows.

When a petition is made to the court to appoint a neutral arbitrator, the court shall nominate five (5) persons from lists of persons supplied by the American Arbitration Association. The parties seeking arbitration and against whom arbitration is sought may within five (5) days of receipt of notice of such nominees from the court jointly select the arbitrator whether or not such arbitrator is among the nominees. If such parties fail to select an arbitrator within the five-day period, the court shall appoint the arbitrator from the nominees.

The cost of the arbitration shall be divided equally between the parties. In cases of extreme hardship, ValueOptions shall assume all or a portion of a Member's share of the fees and expenses of the neutral arbitrator. Upon request, ValueOptions shall provide a Member with an application for relief from such fees and expenses. Approval or denial of the application shall be determined by a neutral arbitrator who is not assigned to hear the underlying dispute, who has been selected pursuant to the immediately preceding paragraph, and whose fees and expenses are paid for by ValueOptions. The arbitrator's award may be enforced in any court having jurisdiction thereof by the filing of a petition to enforce the award. Costs of filing such a petition may be recovered by the party filing the petition.

BY ENTERING INTO THIS AGREEMENT, MEMBERS AGREE TO GIVE UP CONSTITUTIONAL RIGHTS TO HAVE ANY DISPUTE, EXCLUDING THOSE INVOLVING CLAIMS OF MEDICAL MALPRACTICE, DECIDED IN A COURT OF LAW BEFORE A JURY AND INSTEAD ACCEPT THE USE OF ARBITRATION FOR RESOLVING DISPUTES WITH VALUEOPTIONS.

PG&E Claims and Appeals Review Process

If you are not satisfied with the claims and appeals review process completed with ValueOptions, you may elect to use PG&E's Claims and Appeals Review Process, as described below. You have 90 days from the date of receipt of the final decision from ValueOptions to elect this claims and appeals review process.

The first step of the Claims and Appeals Review Process (Step One) is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include a HIPAA AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION form. You can access a copy online from the **Human Resources Forms** section of the PG&E@Work intranet or by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Send your appeal to:

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

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the HIPAA Authorization may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial;
- a reference to the Plan provision(s) which apply to the denial; and
- an explanation of additional appeals procedures.

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

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

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

- the specific reason(s) for the denial;
- 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.

Medical Coverage for Participants on Long-Term Disability

In 2014, if you are an employee receiving benefits under the Long-Term Disability (LTD) Plan sponsored by the Company, your medical plan options will be one or more of the following plans: the Network Access Plan (NAP) or the Comprehensive Access Plan (CAP), both administered by Anthem Blue Cross, the Kaiser Permanente Insurance Company Exclusive Provider Organization (EPO) Plan or Kaiser Senior Advantage. The specific plan(s) that are available to you will be based on your home ZIP code and your Medicare-eligibility.

For details about the Anthem NAP or CAP plans or Kaiser Senior Advantage, see "Medical Coverage" in the *Health Care Benefits* section of the 2011 Summary of Benefits Handbook for IBEW-, ESC- and SEIU-Represented Employees as modified by subsequent Summaries of Material Modifications (e.g., annual open enrollment guides), Evidences of Coverage and insurance policies, or see the most current summary plan description. For details about the Kaiser EPO Plan, please refer to the most current Kaiser Permanente Exclusive Provider Organization Plan Summary of Benefits Handbook.

Please note: Effective January 1, 2013, the Blue Shield and Health Net Plans are no longer offered.

Health Account

If you are an active employee and you are enrolled in the Health Account Plan (HAP), you are eligible to receive credits in a Health Account. You can also earn additional incentive credits when you participate in certain health and wellness activities.

The Health Account is legally considered a "health reimbursement arrangement," which allows you to pay for certain health care services on a before-tax basis using the credits you earn. This means that certain health care services can actually cost you less because you do not pay taxes on the expenses.

When you are enrolled in the HAP, the Company will contribute "credits" to a Health Account for you at the start of every year. You are also eligible to earn incentive credits for your Health Account each year by participating in a health screening and either testing tobacco free or completing a tobacco cessation program. These Health Account activities are administered by PG&E's partner, Provant Health Solutions, a nationally accredited, independent health and wellness company.

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation. The plans and benefits described in this section are also applicable to employees of designated subsidiaries and affiliates, but only to the extent that such entities are participating employers with respect to the described plans and programs and such employees meet the eligibility requirements of the plans or programs.

The Health Account is part of the PG&E-sponsored medical plan for active employees, and you can only enroll in the PG&E-sponsored medical plans 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 "Change-in-Status Events" in the *What If...* section). You are eligible for a Health Account when you enroll in the HAP, and your Health Account becomes automatically active once your account is credited.

Your Health Account administrator will depend on whether you elected the Anthem HAP or the Kaiser (KPIC) HAP. If you elected the Anthem HAP, Your Spending Account (YSA) will administer your Health Account. If you elected the Kaiser HAP, Kaiser Health Payment Services will administer your Health Account.

If you have any questions about the Health Account, IRS rules, or your claims, you may contact your account administrator. Anthem members can call YSA at 800-964-9902 or log on to http://www.yourspendingaccount.com/pge. YSA representatives are available from 5 a.m. to 5 p.m. Pacific time, Monday through Friday. KPIC members can call Kaiser Health Payment Services at 877-750-3399 or visit Kaiser Permanente's website at kp.org/healthpayment. Kaiser Permanente representatives are available from 5 a.m. to 7 p.m. Pacific time, Monday through Friday.

You are not eligible for the Health Account if you are an intern, a contract or agency worker, or a hiring hall employee.

Although the Health Account sounds similar to the Health Care Flexible Spending Account (HCFSA), it is a different type of plan. For information on the HCFSA, see the *Flexible Spending Accounts* section.

In This Section

Health Accounts at a Glance

Health Account	▪ Every January 1, PG&E automatically gives you an annual Health Account credit allocation. ▫ For 2014: You get $750 for single coverage ($500 if you enroll after January 1) or $1,500 for family coverage ($1,000 if you enroll after January 1) ▫ Each year, you can earn an additional $500 for single coverage or $1,000 for family coverage by taking the annual health screening and participating in the tobacco-free program. ▫ You'll get an additional $500 of seed money (both for single or family coverage) if you earn $23.88 or less per hour. ▫ If you switch from single coverage to family coverage mid-year, you will be given the higher level of credits for family coverage. ▪ At the end of each year, any remaining credits in your Health Account will automatically roll forward to the next year, as long as you remain enrolled in the HAP or you otherwise qualify to keep the credits, as described in this section. ▪ If you terminate your PG&E-sponsored HAP coverage, you will forfeit the balance of credits in your Health Account, unless you are otherwise eligible to keep them, as described in this section. ▪ PG&E funds the entire account. For additional information, see "How the Health Account Works" on page 228.

Eligibility

If you are an active employee who is enrolled in the Health Account Plan (HAP), you are eligible to participate in the Health Account. If you terminate your HAP coverage as an active employee (for example, you leave the Company or drop coverage while still actively employed), you will no longer be eligible for the Health Account and will forfeit any balance remaining in the account, unless one of the following occur:

- You subsequently re-enroll in the HAP in the same calendar year, in which case your Health Account balance, if any, will be reinstated.
- You continue your HAP coverage through COBRA,
- You retire and are eligible for PG&E-sponsored retiree medical coverage (whether or not you actually enroll in a retiree medical plan).
- You go on Long-Term Disability and remained enrolled in a PG&E-sponsored medical plan.

When you enroll in HAP coverage through COBRA, you will keep any unused Health Account credit balance, and you also will be eligible to receive the annual Health Account credit allocation at the beginning of the plan year. However, you will not be eligible to earn incentive credits by taking the annual health screening and/or participating in the tobacco-free program. To continue in the HAP after you terminate employment, see "Continuing Coverage Under COBRA" and "Conversion to an Individual Medical Policy" in the *Health Care Participation* section.

If you retire and are eligible for PG&E's retiree medical coverage, you will keep any unused Health Account balance for your future use, even if you waive coverage or enroll in medical coverage elsewhere. However, you will not be eligible for the annual Health Account credit allocation at the beginning of the plan year, nor will you be able to earn incentive credits by taking the annual health screening and/or participating in the tobacco-free program.

If you go on Long-Term Disability, you will no longer be eligible for HAP coverage effective the first of the month following your LTD effective date. Therefore, you will need to select a different PG&E-sponsored medical plan. In 2014, you will keep any unused credits in your Health Account as long as you enroll in a PG&E-sponsored medical plan. However, you will not be eligible for the annual Health Account credit allocation at the beginning of the each plan year, nor will you be able to earn incentive credits by taking the annual health screening and/or participating in the tobacco-free program.

For more information, please see "If You Are on Long-Term Disability or Workers' Compensation" on page 285.

How the Health Account Works

The Company will automatically set up a Health Account for you when you enroll in the HAP and will deposit the annual Company credit allocation into your account. In addition, the Company will credit your account with incentive credit amounts if you complete a qualifying health activity (health screening or tobacco free test/smoking cessation program). It may take three to six weeks for a credit to be reflected in your Health Account. Note that your Health Account is merely a recordkeeping account (also called a "notional" account). Incentive credits you earn will be credited to your Health Account, but the Health Account is not funded with cash. All reimbursements of eligible expenses are made from the Company's general assets. The account has no actual cash value that can be used elsewhere.

You may not contribute to the Health Account by making deposits to your Health Account through payroll deductions from your before-tax or after-tax pay.

For IRS purposes, the Company credits 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 state income taxes are not withheld from any of these credits**, nor are any such taxes due when the money is used to pay for eligible expenses.

How to Earn Credits for Your Health Account

Your Health Account will be established when you enroll in the PG&E-sponsored HAP. You can also earn incentive credits, once a year, when you complete specific Health Account activities, as offered each year by the Company.

You must complete these Health Account activities by the end of the third quarter in any calendar year to earn incentive credits for that year. Health Account activities completed in the fourth quarter will earn incentives for the next calendar year. Incentive credits you earn will be credited to your Health Account shortly after you complete the activity. Credits are not prorated if you enroll in the plan on a midyear basis. Any unused balances will roll over into the next calendar year as long as you remain enrolled in the HAP or otherwise qualify to keep the credits.

Health Screenings

You can take a health screening to earn an annual incentive credit of $250 for single coverage or $500 for family coverage. Your participation in the health screenings earns credits for the entire family. You have a choice of three ways to complete a health screening:

- **On-site at larger PG&E locations:** Specific locations and dates will be determined and communicated annually. The onsite health screening consists of a fasting or non-fasting finger prick to measure total cholesterol, HDL, LDL, triglycerides, LDL/HDL risk ratio and glucose. Body mass index (BMI), height, weight and blood pressure measurements will also be taken.
- **At your health care provider:** If you complete a health screening at your provider's office, you will need to download a Health Screening Results form from Provant's Health & Wellness portal. Your provider must complete the form with results from the past 12 months or order a wellness screening for new results, then submit the form to Provant. Note that a health screening at your health care provider does not include the tobacco screening, which can only be conducted onsite at PG&E or via the concierge service option.
- **Via a concierge service:** You can contact Provant to schedule a health screening (including the tobacco screening) at your home or for small groups at your work location. Screenings must be scheduled at least two weeks in advance. Results for health screenings conducted at home will not be immediately available. You'll be able to access your results online at **https://pge.provantonline.com** two to three weeks after your screening.

Health Account incentive credits will be based on participation, not on outcomes. The purpose of the health screening is to identify any potential health risks so you and your doctor can create a plan for making healthy choices that will lead to overall health improvements. Identifying data, such as your individual results, will not be shared with PG&E. PG&E will only see de-identified summary health screening data in an effort to understand overall health trends and areas that may need attention in PG&E's health and wellness programs. However, in order to receive the additional incentive credits into your Health Account, you must agree to release your personal results to Provant.

You are only eligible for one annual health screening credit each year, even though there may be a change in medical plan coverage during the year.

Tobacco-Free Participation

The health screenings described above also include a test to verify if you are tobacco-free. If you test tobacco free, you will earn an annual $250 credit for single coverage or $500 for family coverage.

If you do not test tobacco free, you can complete a smoking cessation program to earn the credit. The smoking cessation program, administered by Provant, can be completed onsite, telephonically, or online.

The five-week telephonic comprehensive tobacco cessation program is facilitated by a certified tobacco cessation specialist and helps participants improve their health by teaching them the necessary behavior skills required to achieve a tobacco free life. Available via telephone, the program incorporates ICSI (Institute for Clinical System Improvement) and U.S. Surgeon General Guidelines for tobacco use prevention and cessation. PG&E Tobacco Cessation Program onsite and telephonic participants receive a kit with the program that includes: Participant Workbook, Guide Imagery CD, Break IT Survival Kit, Community Resources Information, and Program Completion Certificate.

The telephonic program helps participants:

- Understand the tobacco habit and nicotine addiction
- Identify smoking/tobacco usage triggers and readiness to quit
- Learn various techniques for stopping and remaining tobacco-free;
- Develop strategies to overcome urges; and
- Stay tobacco-free once they have quit

For telephonic participants, Provant health coaches are available: Monday through Friday, 5 a.m. to 5 p.m., Pacific time. As needed, your health coach will also provide you with tools, guidance and information on how to access Provant programs and services to support your journey to better health.

If you would prefer to complete your tobacco cessation program online, the online Tobacco Cessation Workshop is a comprehensive five-week program which focuses on assisting individuals in understanding the risks of smoking and in taking action to successfully quit. The online workshop helps participants overcome the barriers to quitting smoking and developing personal wellness behaviors to maintain success.

Provant also offers both gum and lozenges for participants needing nicotine replacement therapy (NRT). Participants are required to obtain Primary Care authorization and submit an authorization form to Provant in order to obtain nicotine replacement therapy (NRT).

You are only eligible for one annual tobacco-free participation incentive credit each year, even though there may be a change in medical plan coverage during the year.

Appeals Process:

If you fail to earn Health Credits by completing the program's health activities, you have the right to an appeals process. Alternative standards and waiver opportunities may apply for all similarly situated members. If you feel that it is unreasonably difficult to meet the program criteria to earn your incentive due to a medical condition or you would like to appeal your results due to a specific issue that prevents you from being able to meet the criteria as outlined, please call Provant Health at 877-239-3557 to initiate an appeal. Provant Health will proactively work with you and your physician to certify the issue and, if applicable, develop another way for you to qualify for the incentive.

Setting Up Your Health Account

Your Health Account is automatically set up once you enroll in the HAP. Once the account is credited, you can obtain reimbursements for eligible health care claims from the Health Account.

Logging on to Your Health Account for the First Time

- Anthem HAP members should go to www.yourspendingaccount.com/pge. Select the log-in link, then choose New User Registration to create your username and password.
- KPIC HAP members should go to kp.org/healthpayment. If you aren't registered on kp.org, you'll be asked to create a new user ID, password, and security questions the first time you visit.

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.

For more information, contact your account administrator (YSA or Kaiser Health Payment Services).

Reimbursement of Eligible Health Care Expenses

You can use the credits in your Health Account to "pay" for eligible health care expenses as defined by the IRS. When you obtain services that are eligible for reimbursement, you may "withdraw" the credits from your Health Account. Your use of these accounts is limited by the type of expenses you incur. (See the *Flexible Spending Accounts* section for more information.)

If you are covered under both the Health Care Flexible Spending Account (HCFSA) and the Health Account, money will be deducted first from your HCFSA and then from your Health Account. Due to the Department of Treasury's recent modification to the "use it or lose it" rule for the HCFSA, you will be allowed to carry over up to $500 of your HCFSA's unused balance, if any, from one plan year to the next, starting retroactively from the 2013 plan year and thereafter. Unused funds in your Health Account will be rolled over in future years, as long as you remain enrolled in the HAP or otherwise eligible to keep the account. See "Eligibility" on page 227 for information on account forfeitures.

Here are the ways you can pay for eligible health care expenses:

Approach One: Automatic Reimbursement (for KPIC members only)

If you are a KPIC member:

- Any coinsurance or deductible liability that you have incurred will automatically be processed by Kaiser Health Payment Services; and
- If you have sufficient credits in your Health Account, Kaiser Health Payment Services will automatically pay your provider and you do not have to process any payments.

You can turn off this automatic payment feature any time in the calendar year. However, once turned off, it cannot be turned on again until the next calendar year. If you do turn off this feature, you will have to file manual claims. You must call Kaiser Health Payment Services at 877-750-3399 in order to turn off the automatic payment feature for each benefit plan year.

Approach Two: Use Your Health Care Debit Card

You'll automatically receive YSA's or KPIC's debit card in the mail when you enroll in the Health Account. You'll receive a single card even if you're enrolled in more than one account (i.e., a HCFSA and a Health Account). The card is not available for the Dependent Care Flexible Spending Account (DCFSA).

If you are an Anthem member	If you are a KPIC member
▪ Your Spending Account (YSA) will mail you a YSA Card. ▪ Activate your card by following the instructions. ▪ This card can be used for medical, dental, and vision expenses, prescription drugs, and mental health and substance abuse treatment. Your debit card is programmed to work only at providers whose primary business is to provide health care or health care products. ▪ Visit www.yourspendingaccount.com/pge for a list of expenses and locations where you can use your health care debit card.	▪ Kaiser Health Payment Services will mail you a Health Payment Card. ▪ Your card can only be used for prescription drug purchases. Your debit card is programmed to work only at Kaiser Permanente retail pharmacies, the Kaiser Permanente mail-order pharmacy, and some participating non-Kaiser Permanente pharmacies. You should use the card at Kaiser retail pharmacies and the Kaiser mail-order pharmacy to receive benefit coverage. ▪ Activate your card by following the instructions. ▪ Visit kp.org/healthpayment for a list of expenses and locations where you can use your health care debit card.

The available balance on your card will reflect the current amount available in your Health Account. If you also have a Health Care FSA, the available balance on your card will reflect the total available for both accounts.

When you swipe your debit card, the system makes sure that your account is active and that you have sufficient funds for the full amount. If not, the transaction will be denied. As an alternative, you can swipe the card for the amount left in your account and pay the difference with another form of payment, or you can pay out of your pocket and file a claim for reimbursement.

Be sure to keep your itemized receipts as documentation. Although your health care debit card eliminates the need to file paper claims for prescription drugs and medical supplies, your charges must be verified. **Always keep your receipts for tax purposes, in case Your Spending Account (YSA) or Kaiser Health Payment Services needs a receipt, or the IRS requests them to confirm a purchase**. Your Spending Account (YSA) or Kaiser Health Payment Services will notify you within approximately a week from the date of your health care debit card swipe if a receipt is needed. If Your Spending Account (YSA) or Kaiser Health Payment Services has your e-mail information, notification will be electronic. Otherwise, it will be by mail.

If you use the health care debit card for an ineligible expense or for one that Your Spending Account (YSA) or Kaiser Health Payment Services does not have proper documentation, you will be required to reimburse the account for the amount of that transaction.

If you need to order a replacement or additional health care debit card, you can log on to your online account or call Your Spending Account (YSA) at 800-964-9902 or Kaiser Health Payment Services at 877-750-3399 to request another card. Be sure to call as well if your card is lost or stolen.

More details on how to use your health care debit card and how to submit expenses are available by contacting your card administrator. If you are an Anthem member, call Your Spending Account (YSA) at 800-964-9902 or visit www.yourspendingaccount.com/pge. If you are a KPIC member, call Kaiser Health Payment Services at 877-750-3399 or visit kp.org/healthpayment.

Approach Three: Pay for the Expense and File a Claim

You can also pay for out-of-pocket expenses using your own personal credit or debit card, cash or check, and keep your itemized receipt as documentation. Then, log in to your online account to file for reimbursement. For KPIC members, this option applies when you:

- have opted out of the Automatic Reimbursement feature;
- are paying for services not covered under the HAP; or
- have depleted the funds in your Health Account.

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. **Then, log in to your account** by going to www.yourspendingaccount.com/pge and selecting the log-in link if you are an Anthem member, or to kp.org/healthpayment and entering your user ID and password if you are a KPIC member. Follow the prompts to file a claim.

If you need help determining which of your expenses are eligible, you should contact Your Spending Account (YSA) or Kaiser Health Payment Services. Eligibility for reimbursement is based on when services are actually received, regardless of when you pay for such expenses.

Print and mail the completed claim submission form, along with original invoices, receipts, Explanations of Benefits (EOBs), or health plan website claims print-outs to:

If you are an Anthem member	If you are a KPIC member
Your Spending Account (YSA) P.O. Box 785040 Orlando, FL 32878-5040	Kaiser Foundation Health Plan Inc. SF C/O Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540

Be sure to keep a photocopy of everything for yourself before you submit it to the Your Spending Account (YSA) or Kaiser Health Payment Services processing center. Or you may fax your completed claims submission form and a copy of the original invoices to 888-211-9900 if you are an Anthem member or 877-535-0821 if you are a KPIC member. Save a copy of your fax confirmation receipt as proof of successful submission.

Processing of Manual 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 at http://www.yourspendingaccount.com/pge if you are an Anthem member or kp.org/healthpayment if you are a KPIC member. If you choose automatic bank account deposits for your Health Account in any calendar year, the election will automatically roll over when you re-enroll in the Plan for a future year.

How to Avoid Overpayment

When you pay for health care expenses at the doctor, pharmacist, hospital, dentist, or eye doctor, always present your health insurance ID card first to ensure your claims are filed correctly.

Except for pharmacy purchases, if your health care provider asks you to pay at the time of service, don't pay right away. Instead, wait until your claim is processed and you receive your Explanation of Benefits (EOB). This helps avoid overpayment. Compare your EOB with the provider bill to verify the amount being charged by your provider is the same as the patient balance on the EOB. You then may pay using your health care debit card if enough funds are available to pay the expense, or you may use your own personal credit/debit card, cash or check and then request reimbursement online.

How to Handle Claim Adjustments (for YSA Members Only)

"Positive adjustment" is when you owe more money than what you initially paid with your health care debit card. If funds are available, you may use your health care debit card to satisfy the amount or pay your health care provider out of pocket and submit a claim to YSA for reimbursement.

For example, you went to the doctor and you were asked to pay $25 with your health care debit card. Once you received your doctor's bill and Explanation of Benefits (EOB) from your health plan, you were informed that you owed an additional $10. At this point, you can either use your health care debit card to pay for the additional $10 or pay out of pocket and then submit a claim to YSA for reimbursement. However, do not ask your provider to credit the refund back onto your health care debit card, as it will cause claim adjustment problems.

"Negative adjustment" is when you overpay your health care provider. If you receive an EOB or billing statement indicating you owe less or are due a credit after using your health care debit card to pay your health care provider, you will need to contact your provider to receive a refund.

For example, you went to the doctor and you were asked to pay $25 with your health care debit card. Once you received your doctor's bill and EOB from your health plan, you were informed that you were only responsible for $15 instead of $25. At this point, you should contact your provider and request a refund for the amount you overpaid.

Always Save Your Itemized Receipts

Always save your itemized receipts regardless of how you pay. You're responsible for ensuring your withdrawals are for IRS-approved expenses. You'll need your receipts to verify your expenses were eligible if you're ever audited. The IRS may require documentation to show the money was used for qualified expenses. Be sure your receipts have all of these details:

- Date
- Name and address of the provider or merchant
- Description of the service provided or product purchased
- Amount charged

Health care debit card or credit card receipts, non-itemized cash register receipts, and cancelled checks are insufficient. Please be sure you have a doctor's prescription for any over-the-counter medicines you purchase, as the eligibility of over-the-counter items depends on whether you have a prescription. For updated information, visit http://www.yourspendingaccount.com/pge if you are an Anthem member or kp.org/healthpayment if you are a KPIC member.

If requested by Your Spending Account (YSA) or Kaiser Health Payment Services, please be sure to provide your health care debit card receipts within the time frame requested. Otherwise, your payment or swipe transaction will be deemed ineligible and you will be required to refund the amount of transaction. If you fail to submit required receipts within your claim administrator's designated time frames, your debit card will be deactivated. In addition, if you fail to reimburse your account, the total amount of the ineligible expenses may be added to your W-2 as taxable income.

Deadline for Submitting Health Care Claims and Receipts

There is a three-month "run-out" period that ends March 31 of the subsequent plan year during which you can submit and provide supporting documentation to substantiate claims for eligible services rendered in the current year. For example, you will have until March 31, 2015 to submit claims for eligible health care expenses incurred through December 31, 2014, provided funds have not already been exhausted.

Availability of Health Account Credits for Reimbursement

For Health Account claims, you must first be enrolled in the Health Account Plan (HAP) in order for your Health Account to be established and for claims to be reimbursed.

The amount of the reimbursement will depend upon how much money is available in your Health Account and Health Care Flexible Spending Account (HCFSA), if applicable. You will be reimbursed in full for your eligible expenses, provided your (combined) account balance is equal to or greater than the amount of your claim. If your (combined) account balance is less than the amount of your claim, you will receive partial reimbursement for your claim. If you are covered under both the HCFSA and the Health Account, claims will first be paid from your HCFSA.

At the end of each year, any remaining credits in your Health Account will automatically roll forward to the next calendar year, provided you remain enrolled in the HAP or you are otherwise eligible to keep the account. However, if you terminate your HAP coverage as an active employee (for example, you leave the Company or drop coverage while still actively employed), you will no longer be eligible for the Health Account and will forfeit any balance remaining in the account, unless one of the following occurs:

- You subsequently re-enroll in the HAP in the same calendar year, in which case your Health Account balance, if any, will be reinstated.
- You continue your HAP coverage through COBRA,
- You retire and are eligible for PG&E-sponsored retiree medical coverage (whether or not you actually enroll in a retiree medical plan).
- You go on Long-Term Disability and remain enrolled in a PG&E-sponsored medical plan.

To continue in the HAP after you terminate employment, see "Continuing Coverage Under COBRA" and "Conversion to an Individual Medical Policy" in the *Health Care Participation* section.

Different rules apply for funds remaining in a HCFSA at the end of a calendar year. Beginning in the 2013 plan year, up to $500 can be rolled over to the next calendar year. See the *Flexible Spending Accounts* section for full details.

Additional Health Account Credits for Financial Hardship

You may petition to receive additional credits for your Health Account due to a financial hardship. If the petition is granted, you will receive a one-time credit of $1,000 in your Health Account if you have single coverage and a $2,000 credit if you have family coverage. These credits must only be spent on medical expenses that are covered under the HAP. If you have outstanding medical claims at the time of the petition, the claims can be paid through additional Health Account funds.

To be eligible for this provision, you must have reached the out-of-pocket maximum for a minimum of two years in a row. You may be eligible to petition once every two years provided you have reached the out-of-pocket maximum in each of the previous two years. Each petition will be considered separately.

Participants may petition the Company to request additional Health Account credits based on hardship appeal only if they can demonstrate immediate and heavy financial need. Your request, submitted in writing, must describe your financial hardship and provide satisfactory proof of valid hardship.

In reviewing your petition, the Company will look for:

- sufficient proof that you have exhausted all other financial resources—insurance proceeds, liquidation of your other financial assets, other withdrawals and/or loans, and loans from commercial financial intermediaries; and
- documentation that the additional Health Account credits will be used to cover unreimbursed medical expenses for the participant, spouse, dependents (as defined under Internal Revenue Code §152).

As part of its review, the Company will take into consideration your total unreimbursed medical expenses, not just amounts that exceed 7.5% of your adjusted gross income.

No special form is required – you must simply describe your financial hardship in your own words and supply supporting documentation demonstrating your financial hardship (such as eviction notices or past-due bills). In your description, you must provide the purpose for which the additional funds are needed.

You must submit your petition for additional credits in writing to:

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

Within 60 calendar days of the date the petition is received, you will receive a written response. There may be special circumstances where an extension of up to an additional 90 calendar days may be required. You will be notified if such an issue occurs. If the Benefit Department denies your petition, you will receive a written response that will include the reason for the denial and an explanation of additional appeals procedure. You may then have the denial reviewed by the Employee Benefits Appeals Committee (EBAC). You must submit an appeal in writing stating the reasons for the appeal and enclosing all relevant documentation and information that supports the appeal. You will receive the EBAC's decision within 90 calendar days of the EBAC's receipt of the appeal unless there are special circumstances where an extension of up to an additional 90 calendar days may be required.

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; 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; and
- a statement of your right to bring a civil action under section 502(a) of ERISA.

The decision to grant or deny the funding is non-grievable.

Additional Health Credits

If you earn $23.88/hour or less as of January 1, 2014, you'll get an extra $500 in your Health Account on January 1. If you get a raise in 2014, you can still keep the extra $500 in your Health Account. New employees who join the plan during 2014 whose hourly rate is equal to or less than the $23.88/hour rate will receive the additional $500 in their Health Account during the calendar year. This minimum hourly wage rate may be increased every year and, if so, will be communicated during the annual open enrollment period. This additional funding will be automatically added to your account if you are eligible to receive it. Contact Provant Health Solutions at 866-271-8144 or pgesupport@provanthealth.com to receive the additional funding.

If You Have Both a Health Care Flexible Spending Account (HCFSA) and a Health Account

If you participate in both the HCFSA and the Health Account, your health care payment card is programmed to deduct money first from your HCFSA to help you avoid forfeiting unused HCFSA amounts at the end of the year. After you use all the money in your HCFSA, the card will draw from your Health Account. Remember, balances in your Health Account roll over year after year, as long as you remain eligible to keep the account, but only $500 of a HCFSA can be rolled over each year.

What's Eligible and What's Not

Health Account Eligible Expenses

You can use your Health Account to pay for most eligible tax-deductible health care expenses for you and your Eligible Dependents — even if they are not enrolled in a Company-sponsored health care plan.

"Eligible Dependents" Defined

Your Eligible Dependents are individuals who qualify as dependents under Internal Revenue Code Section 152, as modified by Code Section 105, including registered domestic partners.

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. For example, most health care expenses not covered or not paid in full by a health care plan, including deductibles, copayments, coinsurance or other out-of-pocket expenses, such as for prescription drugs and out-of-network services, are eligible expenses. To be eligible, the service must be received during the period in which you are enrolled in the Health Account Plan (HAP). If you are enrolled in the HAP mid-year, for example, expenses incurred before you were enrolled are not eligible for reimbursement. Likewise, if you do not continue enrollment in the HAP, for example, during an unpaid leave of absence, expenses for health care services received during the period of the leave when you were not enrolled in the HAP are not eligible for reimbursement.

Eligible health care expenses are subject to rules set by the IRS. Refer to the IRS Publication 502, Medical and Dental Expenses, available from your local IRS office (or the IRS website at www.irs.gov) for more details on eligible health care expenses. Use IRS Publication 502 with caution, however, as it is meant only to help taxpayers determine what medical expenses can be deducted on their personal income tax returns and not what is reimbursable under a health reimbursement arrangement. Contact your administrator if you need further information about which expenses are reimbursable.

Ineligible Expenses

You cannot use your Health Account credits for any expenses that are paid for by any other medical, dental or vision plans, not considered tax-deductible by the IRS, or not considered an eligible health care item. Refer to the IRS Publication 502, Medical and Dental Expenses, available from your local IRS office (or the IRS website at www.irs.gov) for more details on ineligible health care expenses.

Partial Prepayments

Many medical treatment programs span several plan years. For example, 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. If you have questions about how claims for ongoing treatment programs will be reimbursed, contact Your Spending Account (YSA) at 800-964-9902 or http://www.yourspendingaccount.com/pge if you are an Anthem Blue Cross member or contact Kaiser Health Payment Services at 877-750-3399 or kp.org/healthpayment if you are a KPIC member.

If Eligibility Is Denied

To participate in a benefit plan, you and your dependents must meet the eligibility requirements and enroll or change your enrollment in the time frames specified by the plan. Before filing an eligibility appeal, you may call the HR Service Center first to see if the eligibility issue can be resolved informally.

If you are not satisfied with the outcome of your contact with the HR Service Center, you may file an eligibility appeal with the Plan Administrator by writing to:

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

If the Benefits Department denies your appeal, you will receive written notice of the denial within 60 days of receipt of the initial appeal unless, due to special circumstances, an additional 60 days is required. Such notification will set forth:

- the specific reason(s) for the denial of the appeal;
- 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 appeal and an explanation of why such material or information is necessary; and
- a description of the Plan's review procedures and the time limits applicable to such procedures.

Eligibility Appeals

If you are not satisfied with the Benefit Department's decision on your appeal, 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 decision maker in the appeals process, stating the reasons for your appeal and enclosing all documentation and any additional information to support your appeal.

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 appeal. You may also request, free of charge, access to, or copies of, all documents, records, and other information relevant to your appeal for benefits. The review will take into account all comments, documents, records, and other information submitted by you relating to your appeal, without regard to whether such information was submitted or considered at the initial benefit determination.

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 the EBAC within 60 days of the EBAC's receipt of your appeal unless, due to special circumstances, the EBAC requires additional time to respond, up to another 60 days.

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

- the specific reason(s) for the denial of the appeal;
- a 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 appeal for benefits.

Health Account Claims and Appeals

Claims

If a Health Account claim you submit is denied in part or whole, YSA or KPIC, as the third-party Claims Administrator, will provide you with written notice within 30 days of receiving your claim, with an explanation of why the claim was denied and any materials you can submit that would reverse the denial or perfect the claim. In certain cases an additional 15 days may be required by your 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 of the Claims Administrators receipt of your claim.

Send your claims to:

If you are an Anthem member	If you are a KPIC member
Your Spending Account (YSA) P.O. Box 785040 Orlando, FL 32878-5040	Kaiser Foundation Health Plan Inc. SF C/O Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540

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

Appeals

If you believe this initial determination results in the denial of a Health Account benefit to which you may be entitled, you may appeal to the Plan Administrator.

Send your first appeal to:

If you are an Anthem member	If you are a KPIC member
Your Spending Account (YSA) P.O. Box 785040 Orlando, FL 32878-5040	Kaiser Health Payment Services c/o HSA P.O. Box 1540 Fargo, ND 58107-1540

This appeal must be made in writing within 180 days after receiving written notice of the denial from YSA if you are an Anthem member or from KPIC if you are a KPIC member 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).

To expedite processing, you should also include a HIPAA AUTHORIZATION TO USE AND/OR DISCLOSE PERSONAL HEALTH INFORMATION form. You can access a copy online from the **Human Resources Forms** section of the PG&E@Work intranet site or by calling the HR Service Center at 415-973-4357 or toll-free at 800-788-2363.

YSA or Kaiser Health Payment Services will generally make a decision within 60 days after receiving the appeal and mail or email a copy of the decision to you promptly. The decision will either overrule or uphold the Plan Administrator's earlier determination, based on plan parameters and guidelines received from PG&E. The decision will give specific reasons and references to the Health Account Plan provisions which support YSA's or KPIC's decision.

Questions About Claims for Reimbursement

You should refer any questions about your claims for reimbursement to your Claims Administrator at the following address and phone numbers.

If you are covered by YSA:

Your Spending Account (YSA)
P.O. Box 785040
Orlando, FL 32878-5040

800-964-9902

If you are covered by KPIC:

Kaiser Foundation Health Plan Inc. SF
C/O Health Payment Services
P.O. Box 1540
Fargo, ND 58107-1540

877-750-3399

PG&E's Voluntary Claims and Appeals Review Process

If you are not satisfied with the claims and appeals review process completed with YSA or KPIC, as applicable, you may elect to use PG&E's Voluntary Claims and Appeal Review Process. You have 90 days from the date of receipt of the final decision from YSA or KPIC to elect this claims and appeals review process.

The first step of the Voluntary Claims and Appeals Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include a HIPAA AUTHORIZATION TO USE AND/OR DISCLOSE PERSONAL HEALTH INFORMATION form. You can access a copy online from the **Human Resources Forms** section of the PG&E@Work intranet or by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Send your appeal to:

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

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the HIPAA Authorization may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial;
- a reference to the Plan provision(s) which apply to the denial; and
- an explanation of additional appeals procedures.

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

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

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

- the specific reason(s) for the denial;
- 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.

Using this voluntary process does not restrict your ability to file suit.

More About the Accounts

Account Limitations

The various accounts are governed by IRS regulations. You should keep in mind these regulations and limitations:

- If you have a Health Account, Health Care Flexible Spending Account (HCFSA) and/or a Dependent Care Flexible Spending Account (DCFSA), you cannot transfer money between any of the accounts.
- All of the money in your Health Account must be used to pay for services received after your account has been activated and credited by the Company with Health Account credit. Any unused money left in a Health Account after all expenses for the Plan Year have been submitted will be carried forward into the following year, unless you no longer qualify to keep the account, as described elsewhere in this section.

If You Have Both a Health Care Flexible Spending Account (HCFSA) and a Health Account

If you participate in both the HCFSA and the Health Account, your health care debit card, as well as the auto reimbursement process (Kaiser members only), is programmed to deduct money first from your HCFSA to help you avoid forfeiting unused amounts at the end of the year. After you use all the money in your HCFSA, money will automatically then be drawn from your Health Account. Remember, only $500 from a HCFSA can be rolled over each year, while balances in your Health Account roll over year after year, as long as one of the following occurs:

- You remain enrolled in the Health Account Plan (HAP), whether as an active employee or through COBRA;
- You retire with eligibility for PG&E's retiree medical coverage; or
- You go on Long-Term Disability and remain enrolled in a PG&E medical plan.

Provision	HCFSA	Health Account
Types of eligible expenses you can incur	All IRS Section 213(d) eligible health care expenses	All IRS Section 213(d) eligible health care expenses
When you can start incurring eligible expenses	▪ January 1 of the year for which you open the account, if you enroll during the Open Enrollment period ▪ The date your coverage is effective, if you enroll midyear	**The IRS prohibits you from filing claims for expenses you incur before your Health Account has been established.** You'll be able to incur eligible expenses on or after the date your Health Account is established, **not before**.
How you can pay for eligible expenses	▪ Automatic reimbursement process for KPIC members (unless you turn off the automatic reimbursement feature through Kaiser Health Payment Services) ▪ Your YSA debit card (for Anthem HAP members) ▪ Your Kaiser debit card (for Kaiser HAP members): for pharmacy purchases only ▪ Your own personal credit card, cash or check ▫ You'll need to file a claim for reimbursement	

Deadline for Claim Reimbursements

Claims can be submitted for reimbursement from the Health Account for eligible expenses incurred during the months in which you were covered under the Health Account Plan (HAP). Claims can be submitted to the processing center until March 31 of the following year. Please note that full documentation (all applicable receipts and statements) must be received, along with the claim, by the March 31 deadline. If complete documentation is not received by the March 31 deadline, then your claim will be denied.

If You Take a Leave of Absence Without Pay

If you take a leave of absence without pay and terminate your PG&E-sponsored medical plan coverage, you will no longer be eligible to participate in the Health Account because eligibility for the Health Account is tied to your enrollment in the Health Account Plan (HAP):

- If you return to work and are reinstated in the HAP in the same calendar year, your Health Account will also be reinstated at the previous credit balance (awarded credits less claims processed to date).

- If you do not return to work in the same calendar year, you will forfeit all funds accumulated in your Health Account. Upon returning to work in a different calendar year, a new Health Account will be established with a new credit allocation, but the account will not contain any previously accumulated credit balance from the previous year.

You can submit claims for reimbursement from the Health Account for eligible expenses incurred during the months in which you were an active employee. Claims can be submitted to the processing center until March 31 of the following year.

For more information, please contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363, for more information.

If You Are on Long-Term Disability

If you go on Long-Term Disability (LTD), you will no longer be eligible for HAP coverage effective the first of the month following your LTD effective date. As long as you select a different PG&E sponsored-medical plan, though, you will be eligible to use the remaining credit balance in your Health Account until you exhaust it. However, you will not be eligible to receive the annual Health Account credit allocation at the beginning of each plan year, nor will you be eligible to earn incentive credits by taking the annual health screening and/or participating in the tobacco-free program.

Whether you return to active work in the same calendar year or subsequent year(s), once you resume your active status as an employee and re-enroll in HAP coverage, you will receive the annual Health Account credit allocation at either the single or family level of coverage (provided you have not already received that year's credit allocation). You can also earn incentive credits by taking the annual health screening and/or participating in the tobacco-free program.

For more information, please contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363, for more information.

If You Leave the Company

If you leave the Company, you will no longer be eligible for the Health Account and will forfeit any balances in the account (unless you subsequently become a participant in the HAP again in the same calendar year, in which case your Health Account balance, if any, will be reinstated). If you leave the Company, you can continue your participation in the Health Account when you enroll in the HAP through COBRA (see "Continuing Coverage Under COBRA" and "Conversion to an Individual Medical Policy" in the *Health Care Participation* section). If you enroll in HAP coverage through COBRA, you will keep any unused account balance, and you will also be eligible to receive the annual Health Account credit allocation at the beginning of each plan year. However, you will not be eligible to earn extra credits for taking the annual health screening and/or participating in the tobacco-free program.

If participation is not continued through COBRA, your eligibility will stop at the end of the month in which you leave the Company.

You can submit claims for reimbursement from the Health Account for eligible expenses incurred during the months in which you were an active employee. Claims can be submitted to the processing center until March 31 of the following year. Any money remaining in the account after March 31 of the following year will be forfeited (unless you enroll for the HAP through COBRA).

For more information, please contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363, for more information.

If You Retire

If you retire and are eligible for PG&E-sponsored retiree medical coverage – even if you waive retiree medical coverage when you first retire and subsequently enroll – you can keep your unused Health Account balance and use your credits for eligible health care expenses, including post-tax insurance premiums for medical, dental and vision coverage. However, you won't receive any new credit allocations to your Health Account after you retire because eligibility for the annual credit allocations are tied to enrollment in the HAP, and the HAP is not available to retirees.

The Health Account is different from your Retiree Medical Savings Account (RMSA). You can use the RMSA only for PG&E retiree medical plan premiums.

For more information, please contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363, for more information.

If You Are Re-Hired by the Company

Any money remaining in the account after March 31 of the year following the year in which you leave the Company will be forfeited, unless you enroll in the HAP through COBRA or you are eligible for PG&E-sponsored retiree medical coverage. However, if you leave the Company and are later re-hired by the Company in the same calendar year, your Health Account balance, if any, will be reinstated.

The Health Account and COBRA for Spouses, Registered Domestic Partners and Dependents

In the event of a divorce, dissolution of marriage or legal separation, your former spouse and/or currently covered dependents can continue participation in the Health Account if they enroll in the Health Account Plan (HAP) through COBRA. Your former registered domestic partner can also continue participation through the continuation coverage that PG&E extends to registered domestic partners. (See "Continuing Coverage Under COBRA" and "Conversion to an Individual Medical Policy" in the *Health Care Participation* section). Both forms of continuation coverage are referred to in this section for ease of reference as "COBRA."

If COBRA is elected, a separate Health Account will be established for your former spouse or registered domestic partner by YSA or KPIC, and that account will be credited with the full value of the amount in the employee's account as of the effective date of COBRA coverage. If your former spouse or former registered domestic partner continues coverage for him- or herself as well as for additional dependents through COBRA family coverage, one Health Account will be established and funded in connection with such election of COBRA family coverage. If dependents over the age of 18 enroll for individual COBRA coverage, a separate Health Account will be established for each of them and credited with the full value of the amount in the employee's account as of the effective date of COBRA coverage. During the applicable COBRA-coverage period each such COBRA-established Health Account will be credited every January with the basic, annual credit allocation that PG&E provides for that calendar year to Health Accounts. However, COBRA-established Health Accounts are not eligible to receive any other additional incentive funding or credits which are provided to participating employees. If COBRA is not elected, your former spouse or registered domestic partner as well as dependents' eligibility for the Health Account will stop at the end of the month in which the qualifying event occurred.

Claims can be submitted for reimbursement from the Health Account for eligible expenses incurred during the months in which the former spouse/registered domestic partner and/or dependents were covered under the HAP. Claims can be submitted to the processing center until March 31 of the following year.

If you die, your surviving spouse will inherit any remaining Health Account credits as long as he or she is eligible for and elects medical coverage through PG&E. However, your surviving spouse won't receive any new Health Account credit allocations because the HAP is not available for retirees or surviving spouses.

For more information, please contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363, for more information.

Dental Coverage

The Company offers dental coverage that emphasizes the value of diagnostic and preventive care, while also paying a significant portion of more expensive care when dental work is needed.

Dental coverage is administered by Delta Dental of California. The Plan provides coverage worldwide and allows you to receive care from any licensed dentist. You may seek services from one of the many dentists who belong to the Delta Dentist Network, or you may go to a non-participating dentist.

Eligibility and Enrollment

For information on participating in dental coverage, see the *Health Care Participation* section.

In This Section

Dental Coverage at a Glance

Delta Dental will pay a specified percentage of allowed expenses after you pay any applicable deductibles or coinsurance.

The following chart summarizes what the Plan will reimburse you for covered services. Note: All benefits are subject to Delta Dental's usual, reasonable and customary allowances.

Provisions	Coverage
Choice of Dentist	Any; for maximum benefits, use a PPO or Premier Dentist
Annual Deductible*	Delta Dental PPO Network ▪ $25/person and $75/family Delta Dental Premier Network or Non-Participating Dentist ▪ $50/person and $150/family For all covered services

Provisions	Coverage
Diagnostic and Preventive Care	No deductible You pay 15% of eligible preventive care, including: ▪ Two exams/year ▪ Full-mouth X-rays and Panorex films once every five years ▪ Bitewing X-rays twice/year for dependents up to age 18; once/year for adults age 18 and older ▪ Two cleanings/year ▪ Fluoride treatments ▪ Space maintainers
Basic Care	Deductible required You pay 15% of eligible basic care, including: ▪ Fillings ▪ Root canals ▪ Extractions ▪ Oral surgery ▪ Treatment of the gums (periodontia) ▪ Sealants for eligible dependents under age 16 ▪ Permanent first molars through age 8 ▪ Second molars through age 15
Major Care	Deducible required You pay 15% of eligible major care, including: ▪ Crowns ▪ Inlays ▪ Onlays ▪ Cast restorations ▪ Bridges ▪ Implants
Annual Maximum	$2,500/person (excludes orthodontia)
Orthodontia Benefit	You pay 50% of covered expenses; lifetime maximum benefit of $2,000/person

* If you use only Delta Dental PPO dentists throughout the full calendar year, you will pay the lower deductible. If at any time you use a non-participating dentist or a Delta Dental dentist who is only in the Premier network, the higher deductible will apply. The maximum total deductible you will pay in any calendar year is $50/person or $150/family because you won't be required to pay a separate deductible for using both a PPO dentist and a Delta Dental Premier or non-participating dentist.

In addition to your coinsurance, you are responsible for any charges over what Delta Dental will allow. Please note that the annual deductible, annual maximum and orthodontia lifetime maximum are the same regardless of whether services are received by a Delta Dentist or non-participating dentist.

Reimbursement to members who do not use a Delta Dentist is based on the prevailing fee. The prevailing fee is the applicable percentage of the lesser of the fee charged or the fee which satisfies the majority of Delta Dentists for a single procedure as determined by Delta Dental of California.

How Dental Coverage Works

The Dental Plan is a fee-for-service plan. In other words, the Plan reimburses your covered expenses at a specified percentage after you pay any applicable deductible. You may seek services from one of the many dentists who participate in the Delta Dental PPO Network or Delta Dental Premier Network, or from a non-participating dentist.

A feature of Delta Dental of California is the availability of a network of dentists. Approximately 93% of California dentists participate in the Delta Dental Premier Network. Delta Dental also has another network called the Delta Dental PPO Network that has fewer dentists, but many of the same dentists also participate in the Delta Dental Premier Network. Dentists in both networks file their fees with Delta Dental and agree to accept them as payment in full (these fees are called "usual, reasonable and customary"). You may receive treatment from any licensed dentist. However, there are three advantages to receiving treatment from a dentist in either the Delta Dental PPO Network or the Delta Dental Premier Network:

- Delta Dental pays Delta dentists directly, so there are no claim forms to submit, and you do not have to pay the claims expense upfront.
- The Dental Plan features agreed-upon fees for Delta Dentists, so you won't be responsible for any excess charges above your normal deductible and coinsurance for allowed services.
- You usually save money if you use a dentist that participates with Delta Dental, since Delta generally allows a higher reimbursement base for participating dentists.

When services are provided by a Delta Dental PPO dentist, there is an annual deductible of $25 per person or $75 per family. When services are provided by a Delta Dental Premier Network dentist or a non-participating dentist, there is an annual deductible of $50 per person or $150 per family. You may seek services from dentists in both networks during a calendar year, but once services are rendered by a Delta Dental Premier dentist or a non-participating dentist, the annual deductible will "pop up" to the $50 per person/$150 per family for the rest of the year. The deductibles are coordinated between the Delta Dental PPO and the Delta Dental Premier Network. For example, if you have met the $25 individual annual Delta Dental PPO deductible and then seek services with a Delta Dental Premier Network dentist, the $25 will go towards the $50 individual annual deductible.

If you would like a list of either of the two Delta networks of dentists, call Delta Dental at 888-217-5323 or check its website at www.deltadentalins.com/PG&E.

Non-Participating Dentists

If you receive treatment from a non-participating dentist, you will have to pay the dentist yourself, and then file a claim with Delta Dental for reimbursement. Please be advised that the methodology Delta uses for reimbursing non-participating dentists often results in larger out-of-pocket costs for you. When services are provided to you by a non-participating dentist, there is an annual deductible of $50 per person and $150 per family and your reimbursement from Delta Dental is based on the prevailing fee. The prevailing fee is the applicable percentage of the lesser of the fee charged or the fee which satisfies the majority of Delta Dental Plan of California's Participating Dentists for a single procedure as determined by Delta Dental of California. You will be responsible for any expenses that exceed the reimbursement by Delta Dental. Covered expenses reimbursable to you are determined by Delta Dental. Additionally, you are responsible for paying any expenses not covered by Delta Dental, including any applicable deductible and coinsurance.

Predetermination of Costs

If your dentist (whether or not he or she participates in one of Delta's networks) recommends extensive dental work ($300 or more), you should have your dentist file a "Predetermination" with Delta Dental before the work begins. Delta Dental will provide a predetermination claim notice to both you and your dentist, advising ahead of time whether the proposed treatment is a covered benefit and, if so, how much Delta Dental will pay as well as what your share of the costs will be.

Predetermination of costs does not guarantee payment. It is only an estimate of the amount Delta Dental will pay if you continue to be eligible and meet all the requirements of the Dental Plan at the time the treatment you have planned is completed. If you receive other covered services after receiving a predetermination of costs, Delta Dental will still only pay for covered services up to the $2,500 annual maximum.

The Dental Plan does not cover all services your dentist may deem necessary or appropriate. For instance, while your dentist may recommend three cleanings a year, the Plan covers a total of only two cleanings during a calendar year. Any cleanings provided during periodontal procedures are counted as part of this annual limit.

What's Covered

The Dental Plan provides benefits for diagnostic and preventive care, basic and major care, and orthodontia.

- Diagnostic and Preventive Care — Includes exams and X-rays (and/or Panorex films), cleanings, fluoride treatments and space maintainers.
- Basic Care — Includes fillings, extractions, oral surgery, treatment of the gums (periodontal) and root canals using standard procedures as determined by Delta Dental. Basic Care also includes sealants for Eligible Dependents under age 16 (permanent first molars through age 8 and second molars through age 15) using standard procedures as determined by Delta Dental.
- Major Care — Includes implants, crowns, inlays, onlays, cast restorations and bridges fabricated by using accepted conventional procedures and materials as determined by Delta Dental.
- Orthodontia — Includes braces and retainers to straighten teeth.

Dental Plan

If you use a participating Delta dentist, the Dental Plan pays 85% of covered expenses for Diagnostic and Preventive Care with no deductible. This includes two routine check-ups and two cleanings (including procedures that contain cleanings, such as deep cleaning or scaling) for each covered family member in any calendar year, plus periodontal X-rays and fluoride treatments. (See "Plan Limitations" on page 247.)

If further dental care is needed and you see a Delta Dental Premier Network dentist or a non-participating dentist, you pay the first $50 as your annual individual deductible or $150 as your maximum family deductible. The network the dentist belongs to will determine the deductible amount. If you only seek care from Delta Dental PPO dentists, you will be responsible for a $25 annual deductible, up to a family maximum deductible of $75. If at any time during the year you seek care from a Delta Dental Premier Network or non-participating dentist, your annual deductible will be $50 per person, up to a family maximum deductible of $150.

The Dental Plan pays 85% of covered expenses for Basic Care, such as fillings, and 85% for extractions, oral surgery and treatment of the gums (periodontal). For Major Care covered expenses, such as crowns and implants, the Plan also pays 85%. You pay the rest as your coinsurance. If you use a non-participating dentist, you may be responsible for more than your coinsurance and deductible. The Dental Plan pays up to $2,500 in dental benefits each year for each covered member of your family.

Orthodontic Benefits

For orthodontic services, 50% of the total cost of expenses after your deductible - up to a lifetime maximum of $2,000 per covered family member – is covered by Delta. Orthodontia benefits are paid in two installments. The first installment will be made for 25% of the cost of the approved treatment plan, after deductible. The remaining 25% (subject to the lifetime cap) will be paid 12 months later. As noted here, calculations of orthodontic benefits are based on the total treatment plan amount and are subject to deductibles, the appropriate coinsurance percentage and the patient's lifetime orthodontic maximum of $2,000 for each covered family member.

Plan Limitations

Benefits for the following services are limited as summarized below. Please note that if you exceed the Plan limits, you will be responsible for payment for services beyond the limits. For instance, your dentist may recommend more than two cleanings per year. While more cleanings may be advisable, the Plan will only cover the cost for two annual cleanings. You will be responsible for the cost of additional cleanings.

Diagnostic and Preventive Benefits

- Oral Examinations — Benefits are limited to two oral exams in a calendar year (January through December), while you are eligible under any Delta Dental plan.
- Prophylaxis (cleanings) — Cleanings (including procedures that contain cleanings, such as deep cleaning or scaling) and fluoride treatments are covered only twice in a calendar year, while you are eligible under any Delta Dental plan.
- Full Mouth X-rays — Complete mouth X-rays and Panorex films are covered only once every five years while you are eligible under any Delta Dental plan, unless your dentist shows a special need for an increased frequency and submits documentation to and receives authorization from Delta Dental. (Panorex films may be covered even if you receive a full-mouth X-ray.)
- Supplementary Bitewing X-rays — Supplementary bitewing X-rays are covered only:
  - Twice in a calendar year for Eligible Dependents up to age 18, while they are eligible under any Delta Dental plan, or
  - Once a calendar year for adults age 18 and over, while they are eligible under any Delta Dental plan.

If you or your dentist needs to reschedule an appointment, it is your responsibility to ensure the rescheduled appointment still meets the timing limitations of the Dental Plan in order to receive applicable benefits.

Basic Care Benefits

- Periodontal Procedures — Limited to two in a calendar year. If such procedures include prophylaxis (cleanings, including procedures that contain cleanings, such as deep cleaning or scaling), those cleanings are counted towards the annual limit.
- Sealants — Pit and fissure sealants are limited to Eligible Dependents under age 16 (permanent first molars through age 8 and second molars through age 15) using standard procedures as determined by Delta Dental. Sealant benefits include the application of sealants only to permanent posterior molar teeth with no decay, with no restorations and with occlusal surface intact. Sealant benefits do not include the repair or replacement of a sealant on any tooth within two years (24 months) of its application.

Major Care Benefits

- Crowns, Inlays, Onlays and Cast Restorations — If you receive any such restoration while a member of a Company-sponsored Dental Plan or any other plan provided through Delta Dental, a restoration for the same tooth can only be replaced after five years, unless Delta determines that replacement is required because the restoration is unsatisfactory or the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.
- Prosthodontic Benefits — The Dental Plan will pay the applicable percentage of the dentist's filed fee for standard cast chrome or acrylic complete or partial dentures (removable prosthetic appliances provided to replace missing natural, permanent teeth which are constructed using accepted conventional procedures and materials). Benefits for prosthodontic appliances are paid by Delta only once every five years, unless Delta determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta plan will be made if it is unsatisfactory and cannot be made satisfactory.
- Implants — For implants (materials implanted into or on bone or soft tissue) or the removal of implants, you pay 15% (subject to the annual maximum benefit of $2,500). What is covered for implants includes the placement of the implant, abutment, and prosthetic device. Before work begins, you should have your dentist file a "Predetermination" with Delta Dental to review whether the proposed treatment is a covered benefit.

Orthodontic Benefits

- Covered expenses for Delta Dentists are limited to the lesser of the usual, reasonable and customary fee or the fee actually charged.
- Orthodontic services which are begun before a member's coverage date are not covered.
- Periodic payments for orthodontics paid by the Dental Plan shall terminate on the next payment due date after the earliest of the following:
  - the date the employee's participation in the Dental Plan terminates;
  - the first day of the month following the month in which a dependent ceases to meet the definition of a dependent as stated in the Dental Plan;
  - the date treatment is terminated for any reason prior to completion of the treatment plan; or
  - the date the Dental Plan terminates.
- Repair or replacement of an orthodontic appliance furnished in whole or in part is not covered.
- X-rays and extraction procedures related to orthodontics are not covered under orthodontic benefits, but may be covered under other benefits as stated in the Dental Plan.

Other Limitations

- Alternative Treatment — If you choose an alternative treatment that costs more than the usual, reasonable and customary fee of the standard treatment, you will be responsible for the difference in cost in addition to your annual deductible and appropriate coinsurance.

What's Not Covered

The following list includes, but is not limited to, services the Dental Plan will not pay for:

- Services covered under Workers' Compensation or employers' liability laws.
- Services provided by any government agency.
- Services or supplies that are not covered expenses, as determined by Delta Dental.
- Charges in excess of the usual, reasonable and customary fee, the prevailing fee or the filed fee, as determined by Delta Dental. (The prevailing fee is the applicable percentage of the lesser of the fee charged or the fee which satisfies the majority of Delta Dental Plan of California's Participating Dentists for a single procedure, as determined by Delta Dental of California.)
- Services and supplies for cosmetic purposes or for conditions that are a result of hereditary or developmental defects (such as cleft palate, upper and lower jaw malformations, congenitally missing teeth, and the bleaching of teeth that are discolored or lacking enamel).
- Services and supplies for restoring tooth structure lost from wear, rebuilding or maintaining chewing surfaces due to alignment or occlusion, or stabilizing of the teeth.
- Prosthodontic services and supplies or any single procedure that began before coverage for you or your Eligible Dependents started under the Dental Plan. A single procedure is defined as a dental procedure to which a separate procedure number is assigned.
- Prescribed drugs, premedication or analgesia.
- Prophylaxis (cleanings), if the participant has already received two cleanings (including cleanings provided during periodontal procedures) covered by the Plan in the current calendar year.
- Hospital costs and additional fees charged by a dentist or physician for hospital treatment.

- Anesthesia or sedation, except general anesthesia or sedation administered by a licensed dentist or physician in connection with covered oral surgery, select endodontic and periodontal surgeries, and except for children under age 3 or other individuals whose special needs require general anesthesia or sedation to enhance the safety and success of the procedure.
- Extraoral grafts (grafting of tissues from outside of the mouth to oral tissue).
- Bone grafts in conjunction with, or subsequent to, extractions or implant procedures. Periodontal surgery, where bone grafting is performed, is covered only when performed on natural teeth.
- Diagnosis or treatment of any condition related to temporomandibular (jaw) joint dysfunction (TMJD) or associated musculature, nerves and other tissues.
- Replacement of existing restorations for any purpose other than restoring active carious lesions (tooth decay).
- Services or supplies which are experimental in nature, as determined by Delta Dental. Experimental services and supplies include any treatment, therapy, procedure, equipment or equipment usage, device or device usage, or supplies which Delta Dental determines in its sole discretion are not recognized, in accordance with generally accepted professional dental care standards, as being safe and effective for use in the treatment of the illness or condition at issue.
- Services and supplies covered under any other Company-sponsored health plan or benefit program.
- Services and supplies for cast restorations due to cracks, fracture lines or "craze lines" unless there is significant tooth structure missing due to decay or fracture that results in displacement of the tooth structure.
- Services and supplies which are not necessary and customary dental care, as determined by Delta Dental.
- Charges for failure to appear as scheduled for an appointment.
- Services for completion of claim forms or filing of claims.
- Replacement of lost or stolen prosthetic devices.
- Services or supplies rendered or furnished with any duplicate prosthetic device, denture, or any other duplicate appliance.
- Repair or replacement of an orthodontic appliance furnished, in whole or in part.
- Educational programs, such as training in plaque control or oral hygiene, or for dietary instructions.
- Sealants (except as stated under Plan Limitations).
- Services or supplies in connection with periodontal splinting.
- Benefits provided under the extension of benefits provisions of any disability insurance policy, dental care service, hospital service plan contract or self-insured welfare benefit plan.
- Benefits provided under any other dental care service plan contract, or under any similar group contractual arrangement (such as an HMO contract).

Additional exclusions apply to all the health care plans. See "Reductions/Exclusions for Duplicate Coverage" in the *Health Care Participation* section.

Some of the items not covered by the Dental Plan may be covered by your medical plan, if medically necessary. Please check with your medical plan's member services department for more information.

Third Party Exclusion

The Plan contains exclusions for injury, illness or other conditions for which a third party may be liable or legally responsible by reason of negligence, intentional action or breach of legal obligation. These exclusions, limitations, and conditions are described under "Subrogation and Reimbursement" under "If You Have Other Coverage" in the *Health Care Participation* section.

Claims and Appeals

Delta Dental is the Claims Administrator for the PG&E Dental Plan. Delta Dental contracts with a network of participating dentists that bill Delta Dental directly. When you use a participating dentist, you pay only the applicable deductibles and coinsurance.

If you use a non-participating dentist, you generally must pay the dentist first and then file a claim for reimbursement with Delta Dental. All claims for reimbursement of dental expenses must be made within six months of the date on which services or supplies were received. A claim form is available by calling Delta Dental at 888-217-5323 or going to Delta's website at www.deltadentalins.com/PG&E.

After your claim is reviewed, Delta will send you a Notice of Payment that explains how your claim was processed. The Notice of Payment will detail any payments made, indicate if any dental services or claims were denied in whole or in part, and, if so, state the reason(s) for the denial. Upon request and free of charge, Delta will provide you with a copy of any internal rule, guideline or protocol, and/or an explanation of any scientific or clinical judgment relied upon in denying the claim.

Claims and Inquiries

If you have any questions regarding claims, eligibility, or benefits, you may call Delta's Customer and Member Service Department toll-free at 888-217-5323 between 5 a.m. and 5 p.m., Pacific time. Many problems, complaints and claim issues can be resolved informally. You may also contact Delta's Customer and Member Service Department via fax at 800-749-2227 or via e-mail at cms@delta.org. If you have any questions about the services received from a Delta dentist, Delta recommends that you discuss the matter with the dentist before calling Delta.

For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Care Plan for Active Employees or to make election changes to your coverage under the Plan, see "If Eligibility Is Denied" in the *Health Care Participation* section.

Complaints and Appeals

Quality Complaints

If you have a complaint regarding the quality of dental services performed by a Delta dentist, you may contact Delta toll-free at 888-217-5323 between 5 a.m. and 5 p.m., Pacific time. You may submit a written complaint or use a Dental Treatment Complaint Form, which is available from Delta upon request. Send your written complaint or Dental Treatment Complaint Form to:

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

Your quality of care complaint will be referred to Delta's Quality Assessment Department. This department tracks complaints against dentists and handles any concerns as set forth in Delta's Quality Assessment Plan. The Public and Professional Relations Committee of Delta's Board of Directors reviews quarterly reports of emergent patterns of complaints.

Appeals

If you or your dentist are not satisfied with a decision made by Delta Dental and would like to appeal a denial of benefits, you must do so within 180 days of receipt of the notice of denial. You may send a written appeal or complete a Delta Dental Complaint Form, which can be obtained by calling Delta Dental at 888-217-5323 or by going to Delta's website at www.deltadentalins.com/PG&E. Your appeal should include the reason for the appeal, your subscriber I.D. number, and the claim number found on the Notice of Payment.

Send your appeal to:

Delta Dental of California
Attention: Appeals
P.O. Box 997330
Sacramento, CA 95899-7730

Delta will resolve written appeals within 60 days of receipt. The 60-day period is calculated from the date on which Delta receives your written appeal.

A dentist who was not involved with the original determination will review your appeal. The dentist will review all information submitted by you and/or your dentist and will not give deference to Delta's original claim determination. Delta's decision will be based on whether or not the benefits are covered by the Plan.

If Delta denies your appeal, Delta will notify you (and your dentist, if your dentist submitted the appeal) of its decision. The notice shall include the specific reason(s) for the denial including a reference to group contract provisions. You have the right to request, free of charge, a copy of the information that Delta used in reviewing your case.

At this point, if your appeal is denied and you are not satisfied with the decision, you can bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

PG&E's Voluntary Claims and Appeals Review Process

If you are not satisfied with the claims and appeals review process completed with Delta Dental, you may elect to use PG&E's Voluntary Claims and Appeals Review Process, as described below. You have 90 days from the date of receipt of the final decision from Dental Delta to elect this voluntary claims and appeals review process. Initiation of the Voluntary Claims and Appeals Review Process does not restrict your ability to bring a civil action against the Plan.

The first step of the Voluntary Claims and Appeals Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include a HIPAA AUTHORIZATION TO USE AND/OR DISCLOSE PERSONAL HEALTH INFORMATION form. You can access a copy online from the **Human Resources Forms** section of the PG&E@Work intranet or by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Send your appeal to:

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

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the HIPAA Authorization may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial;
- a reference to the Plan provision(s) which apply to the denial; and
- an explanation of additional appeals procedures.

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

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

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

- the specific reason(s) for the denial;
- 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.

Vision Coverage

Vision care is administered by Vision Service Plan (VSP), which has a network of over 27,000 eye doctors. While you may receive vision care from any doctor you choose, using a VSP-network doctor has two advantages:

- Vision Service Plan pays VSP doctors directly, so there are no claim forms to submit. If you go to a non-VSP doctor, you will have to pay the doctor yourself and then file a claim with VSP for reimbursement. Your benefits will be less if you use a non-VSP doctor.
- Exams, standard lenses and frames, or medically necessary contact lenses from VSP doctors are covered after you pay a $10 exam copayment and/or a $25 materials copayment. Both copayments apply to each covered person. Please see How the Plan Works on page 253 for more details. For services and supplies you receive from non-VSP doctors, you will receive an allowance from VSP for covered services which generally will not fully reimburse you for all of your expenses.

In This Section

How the Plan Works

Questions?

Call 800-877-7195 if you have questions regarding any VSP services.

To be assured of full benefits from Vision Service Plan (VSP), you must receive care from a doctor who is a participating member of the VSP network. You are not required to obtain an authorization form to use your VSP benefits. Simply follow these steps:

- Contact your VSP network doctor to make an appointment. If you need help locating a VSP network doctor, call VSP at 800-877-7195. You can also access VSP's website at www.vsp.com for a list of participating doctors or to obtain information on your eligibility.
- Identify yourself, or your dependent, as a VSP member when calling your doctor's office. Provide your name, date of birth and, if necessary, the last four digits of your Social Security number and tell the doctor that you are an employee of the Company. Your doctor will verify your eligibility and coverage with VSP and then obtain the necessary authorization for services.
- After you pay a $10 exam copayment and/or a $25 materials copayment, VSP will pay your VSP doctor directly for all remaining covered charges. Any additional charges for your frames and lenses beyond VSP's network allowances will be your responsibility. Please refer to *Extra Charges* under What the Plan Does Not Cover on page 255 for more information.

Non-VSP Providers

When you receive vision care from a provider who is not a member of VSP, you pay the provider yourself and then submit a claim for reimbursement. Send a copy of the itemized bill(s) to VSP with an HCFA-1500 form or any generic insurance claim form that may be available from your non-participating provider. Claim forms are also available on www.vsp.com. The following information must also be included in your documentation:

- patient's name and mailing address; and
- your identification number (usually the employee's Social Security number).

Mail the itemized bill(s) and claim form to the following address:

Vision Service Plan
P. O. Box 997105
Sacramento, CA 95899-7105

Please note that claims for reimbursement must be filed within 12 months of the date on which services were completed. You will be reimbursed according to a schedule of allowances. (See What the Plan Does Not Cover on page 255.)

VSP's network of doctors is only in the United States. Reimbursements for the services of non-network providers outside the United States are based on the currency conversion rate on the date of service.

Benefits with VSP Providers

If you use a VSP network provider, then after you pay a $10 exam copayment and/or a $25 copayment for materials (lenses and frames), VSP provides:

- Vision exams — Once every 12 months.
- Prescription lenses
  - Eyeglass lenses — Every 12 months, provided you need them. There is an extra charge for non-covered lens enhancements (see *Extra Charges* under What the Plan Does Not Cover on page 255). The extra cost is your responsibility.
  - Medically necessary contact lenses — Medically necessary contact lenses are covered in full from a VSP doctor for certain eye conditions that would prohibit the use of glasses. Your VSP doctor will obtain authorization from VSP. You will not be entitled to benefits for eyeglass lenses and/or frames for 12 months following the date on which medically necessary contact lenses are received.
  - Elective contact lenses — Elective contacts are those that are not considered to be medically necessary. If you choose elective contacts, VSP will pay up to $150 toward the contacts and evaluation/fitting fees. You

will not be entitled to benefits for eyeglass lenses and/or frames for 12 months following the date on which elective contact lenses are received.

- Ultraviolet (UV) protected lenses — Covered at 100% after copayment, if received from a VSP doctor.
- Photochromic lenses (lenses that darken in the sunlight) — Covered at 100% after copayment, if obtained from a VSP doctor.

- Frames — Every 24 months, provided you need them. Many designs are available at no charge after you pay your $25 copayment; however, you will be responsible for any cost that exceeds the $150 plan allowance.
- Lasik surgery — Covered if performed by a VSP doctor, up to $250 per eye (lifetime limit).

Benefits with Non-VSP Providers

If you do not use a VSP network doctor, your reimbursement will be limited to the following schedule:

Schedule	
Exam	$45
Lenses	
Single Vision	$30
Bifocal	$50
Trifocal	$65
Lenticular	$100
Progressive	$50
Ultraviolet (UV) Protected	Not covered
Photochromic	Not covered
Frames	$70
Contacts	
Medically Necessary	$250
Elective	$105 (including contact lens exam)
Lasik Surgery	Not covered

What the Plan Does Not Cover

The Vision Plan does not cover:

- Services or supplies that are not covered expenses, as determined solely by VSP.
- Orthoptics or vision training and any associated supplemental testing; plano (non-prescription) lenses; or two pairs of eyeglasses, in lieu of bifocals.
- Replacement of lost, stolen or broken eyeglass lenses within 12 months of when you received them; replacement of lost, stolen or broken frames within 24 months of when you received them.
- Medical or surgical treatment of the eyes, except as specified under Benefits with VSP Providers.
- Any eye exam or any corrective eyewear that is required as a condition of employment.
- Vision examinations performed in excess of once every 12 months; lenses provided in excess of one pair every 12 months, and frames provided in excess of one every 24 months, whether or not replacement is necessary for your visual welfare.

- Services or supplies for which no charge would be made in the absence of vision care benefits.
- Services or supplies that are not necessary for your visual welfare, as determined by VSP.
- Fees charged by a VSP network doctor that are in excess of the negotiated rates between VSP and the VSP network doctor.
- Laser eye surgery performed by non-VSP providers.

Additional exclusions apply to all the health care plans. See "Reductions/Exclusions for Duplicate Coverage in the *Health Care Participation* section.

Extra Charges

The Vision Plan covers vision care services that are medically necessary. You will have to pay an extra charge for certain services that are primarily for cosmetic purposes. These include, but are not limited to:

- Blended lenses
- Contact lenses (except as noted)
- Oversized lenses
- Photochromic lenses (lenses that darken in the sunlight) obtained from non-VSP providers
- Tinted lenses, except pink #1 and pink #2
- Progressive multifocal lenses
- Coating or lamination of lenses
- Frames that cost more than the VSP allowance
- Low vision care (certain limitations apply)
- Cosmetic lenses
- Optional cosmetic processes
- Ultraviolet (UV) protected lenses obtained from non-VSP providers

Value-Added Discounts from VSP Doctors

Your VSP doctor will provide a 20% discount toward the purchase of additional complete pairs of glasses (lenses and frames). This discount applies to complete pairs of prescription and non-prescription glasses, including sunglasses, that you purchase in addition to those covered by the program. The discount is available from any VSP doctor within 12 months of the date of your last covered eye exam.

Your VSP doctor will also provide a 15% discount off the cost of your contact lens exam (fitting and evaluation). The discount does not apply to the cost of the contact lenses.

The most popular lens enhancements are covered after a copay, saving you an average of 20-25%; see your VSP doctor for special pricing on additional lens enhancements. Your VSP doctor will provide a 20% discount on your out-of-pocket costs if you choose a frame valued at more than your plan allowance.

Claims and Appeals

For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Care Plan for Active Employees or to make election changes to your coverage under the Plan, see the *Health Care Participation* section.

Claims

Vision Service Plan (VSP) is the Claims Administrator for the Vision Plan. VSP has a network of doctors who provide vision services and who will file a claim with VSP on your behalf. You simply make the appropriate copayments to the provider.

If you use a non-participating provider, you will be required to pay the provider and file a claim with VSP. Claim forms are available by calling VSP at 800-877-7195, or visit VSP's website at www.vsp.com. If your claim is approved, the appropriate benefits will be paid to you. All claims for vision plan benefits must be made within 12 months of the date on which services or materials were received.

After your claim is processed, VSP will send you a written notice of its decision within 30 days of receipt of your claim. If your claim is denied in whole or in part, the notice will include the specific reason(s) for the denial and references to the specific plan provision(s) on which the denial is based. You will also receive a description of any additional information needed to obtain approval of your claim and an explanation of why it is necessary. Upon request and free of charge, VSP will provide a copy of the applicable regulation, protocol, and/or explanation of any scientific or clinical judgment used in the denial.

Complaints and Appeals

Before you officially appeal a denial of a vision claim, you can call VSP at 800-877-7195 to see if an informal resolution is possible. However, if you aren't satisfied with VSP's explanation of why the claim was denied, you can request to have the claim reviewed.

VSP will handle and resolve your benefit issues differently, depending on whether your issue is a complaint or an appeal. Under each type of resolution approach, you should first call VSP at 800-877-7195.

Complaints

If you ever have a complaint, your first step is to call VSP's Member Service Department's toll-free number at 800-877-7195, Monday through Friday, between 5 a.m. and 8 p.m., and Saturday, between 7 a.m. and 5 p.m. Pacific time. Complaints are defined as disagreements regarding access to care, quality of care, treatment, or service. You also have the right to submit written comments or supporting documentation concerning a complaint to assist in VSP's review. Every effort will be made by VSP's Member Service Department to answer your question and/or resolve the matter informally. If a matter is not initially resolved to your satisfaction, you may communicate a complaint to VSP in writing by using a complaint form, which may be obtained upon request from VSP's Member Service Department.

Your complaint form should be sent to:

Vision Service Plan
Attn: Complaints and Grievance Unit
P.O. Box 997100
Sacramento, CA 95899-7100

Upon receipt of a verbal or written complaint, VSP will acknowledge, in writing, the receipt and/or disposition of the complaint within five business days. VSP will resolve the complaint within 30 days of receipt, unless special circumstances require an extension of time. In such special circumstances, a 15-day interim notification will be sent to you informing you of the resolution's status. Resolution will be achieved as soon as possible, but no later than 120 days after VSP's receipt of the complaint. Upon final resolution, you will be notified of the outcome in writing.

Appeals

If you are not satisfied with a VSP claim decision, you or your authorized representative may submit a written appeal to VSP. Your appeal must be submitted in writing within 180 days of the date on which the claim was denied. Your appeal should include the name and Social Security number of the employee, along with the name and date of birth of the participant (which may be you or your Eligible Dependent).

Send your appeal to:

Vision Service Plan
Attn: Appeals Department
P.O. Box 2350
Rancho Cordova, CA 95670

VSP's review will take into account all of the information you submit with your appeal, regardless of whether such information was submitted or considered in the initial claim decision. VSP's review determination will be completed within 30 days of VSP's receipt of your request for review.

If, on appeal, VSP determines that your explanation and additional information support the payment of your claim, VSP will process your claim. If your appeal is denied, you will be provided with the specific reason(s) for the decision and the Plan provision(s) on which the decision was based. You have the right to receive, only upon request and at no charge, the information that VSP used to review your appeal.

If you are not satisfied with VSP's decision, you may request a second level of review. To initiate a second level of appeal, you must submit the appeal in writing to Vision Service Plan. A qualified individual who was not involved in the review of your original appeal will review your second appeal. A decision regarding your request will be sent to you within 30 days of VSP's receipt of your appeal. (The one exception to the appeals response timeframes is for medically necessary contacts, which require preauthorization. In this situation, both levels of appeal will be handled within 15 days of VSP's receipt of your request.)

Your Right to External Review by an Independent Review Organization (IRO)

If the outcome of all mandatory appeals is adverse to you, you can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. To be eligible for independent external review your claim must involve medical judgment or a rescission of coverage. Also to be eligible for independent external review, generally, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal to both the plan and request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

Requesting External Review

To file for an independent external review, VSP must receive your external review request within four months of the date of the adverse benefit determination. (If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline is the next business day). Submit your request to:

Vision Service Plan
Attn: Appeals Department
P.O. Box 2350
Rancho Cordova, CA 95670

Expedited External Review

If you submit an urgent external review request, the Plan will immediately determine if you are eligible for an urgent external review. Urgent processing will be granted if, in the judgment of the Plan, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition,

would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. If you are eligible for urgent processing, the Plan will immediately determine if you are eligible for an external review and send you a letter notifying you whether your request for external review has been approved.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO. The IRO will notify you in writing that the request for an external review was received. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 72 hours and send you and VSP written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA Section 502(a).

All Other Review Requests

If you submit an external review request, the Plan will review, within 5 business days, your claim to determine if you are eligible for external review, and within 1 business day of its decision, send you a letter notifying you whether your request has been approved for external review.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO within five business days. The IRO will notify you in writing that it has received the request for an external review. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 45 calendar days and send you and VSP written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA Section 502(a).

Your Claim After External Review

You may have certain additional rights if you remain dissatisfied after you have exhausted all levels of review including external review. Since you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under Section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 866-444-EBSA (3272). In addition, states with Consumer Assistance Programs under PHS Act Section 2793 may be available in your state for assistance.

A list of the state Consumer Assistance Programs is available at www.dol.gov/ebsa/capupdatelist.doc.

PG&E Voluntary Claims and Appeals Review Process

If you are not satisfied with the claims and appeals review process completed with VSP, you may elect to use PG&E's Voluntary Claims and Appeals Review Process, as described below, or elect to bring a civil action. You have 90 days from the date of receipt of the final decision from VSP to elect this voluntary claims and appeals review process. Initiation of the Voluntary Claims and Appeals Review Process does not restrict your ability to bring a civil action against the Plan.

The first step of the Voluntary Claims and Appeals Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include a HIPAA AUTHORIZATION TO USE AND/OR DISCLOSE PERSONAL HEALTH INFORMATION form. You can access a copy online from the **Human Resources Forms** section of the PG&E@Work intranet or by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Send your appeal to:

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

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the HIPAA Authorization may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial;
- a reference to the Plan provision(s) which apply to the denial; and
- an explanation of additional appeals procedures.

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

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

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

- the specific reason(s) for the denial;
- 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.

Flexible Spending Accounts (FSAs)

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 flexible spending accounts (FSAs) each year.

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.

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation. The plans and benefits described in this section are also applicable to employees of designated subsidiaries and affiliates, but only to the extent that such entities are participating employers with respect to the described plans or programs and such employees meet the eligibility requirements of the plans or programs.

Additional Information

In addition to the information in this section, there is also important information about your benefits in other parts of this Handbook. Be sure to review the *About this Handbook* section, the *Benefits at a Glance* section, the *What If...* section, and the *Rules, Regulations & Administrative Information* section.

Note that the Dependent Care Flexible Spending Account (DCFSA) is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

In This Section

Flexible Spending Accounts (FSAs) at a Glance

There are two types of flexible spending accounts (FSAs):

- Health Care Flexible Spending Account (HCFSA)
- Dependent Care Flexible Spending Account (DCFSA)
- **Note:** These accounts were formerly referred to, respectively, as the Health Care Reimbursement Account (HCRA), and the Dependent Care Reimbursement Account (DCRA).

Health Care Flexible Spending Account (HCFSA)	▪ The account allows you to set aside pre-tax contributions, to reimburse your eligible health care expenses that are not covered by health care plans. ▪ You can allocate between $50 and $2,500 a year per individual. For additional information, see "How Health Care Flexible Spending Accounts (HCFSAs) and Dependent Care Flexible Spending Accounts (DCFSAs) Work" on page 264.
Dependent Care Flexible Spending Account (DCFSA)	▪ The account allows you to set aside pre-tax contributions, to reimburse your eligible expenses to care for children or other dependents so you can work or attend school. ▪ You can allocate between $50 and $5,000 a year per individual or married couple filing a joint tax return. (Employees with a spouse filing separate tax returns may each contribute up to $2,500.) For additional information, see "How Health Care Flexible Spending Accounts (HCFSAs) and Dependent Care Flexible Spending Accounts (DCFSAs) Work" on page 264.

How this Section Is Organized

Health Care Flexible Spending Accounts (HCFSAs) and Dependent Care Flexible Spending Accounts (DCFSAs) are very similar and follow many of the same rules. To help you keep the rules straight, this section describes how HCFSAs and DCFSAs work, and then provides specific explanations of each of these two accounts.

Plan Documents Govern

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

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

How Health Care Flexible Spending Accounts (HCFSAs) and Dependent Care Flexible Spending Accounts (DCFSAs) Work

Eligibility, Enrollment and Administration

You are eligible to enroll in the flexible spending accounts (FSAs) 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 "Change-in-Status Events" in the *What If…* section).

You set up your FSA(s) by designating an annual contribution amount when you enroll.

You are not eligible for FSA benefits if you are a contract or agency worker, employee receiving long-term disability benefits, 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 Health Care Flexible Spending Accounts (HCFSAs) and Dependent Care Flexible Spending Accounts (DCFSAs) are administered by a third-party claims administrator:

- Your Spending Account (YSA) if you are an Anthem Blue Cross (Anthem) member or if you have waived PG&E-sponsored medical coverage, or
- Kaiser Health Payment Services if you are a Kaiser Permanente (KPIC) member.

If you have any questions about the Plan, IRS rules, or your claims, you may contact:

If you are an Anthem member or you have waived PG&E-sponsored medical coverage	If you are a KPIC member
Your Spending Account (YSA) 800-964-9902 Service hours: 5 a.m. to 5 p.m., Pacific time, Monday through Friday	Kaiser Health Payment Services 877-750-3399 Service hours: 5 a.m. to 7 p.m., Pacific time; Monday through Friday

Setting Up Your Flexible Spending 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 "Change-in-Status Events" in the *What If…* section).

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 Flexible Spending Account (HCFSA)

You can allocate between $50 and $2,500 a year per individual.

Dependent Care Flexible Spending Account (DCFSA)

You can allocate between $50 and $5,000 a year per individual or married couple filing a joint tax return. (Employees with a 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 Dependent Care Flexible Spending Account (DCFSA), if you are filing jointly.

If your spouse is a full-time student or mentally or physically disabled, he or she is considered to have an annual income of $3,000 if you have one eligible child, or $6,000 if you have more than one eligible child.

The contribution rules for married individuals do not apply to an employee with a registered domestic partner. Domestic partners are considered two unattached individuals who can open separate FSAs, each with the applicable individual contribution limits as prescribed by the IRS.

For more information, contact Your Spending Account (YSA) at 800-964-9902 if you are an Anthem member or you have waived PG&E-sponsored medical coverage, or Kaiser Health Payment Services at 877-750-3399 if you are a KPIC member.

Required Contribution Changes

The Company 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 flexible spending accounts (FSAs) are affected.

Putting Money into Your Flexible Spending Accounts (FSAs)

You may contribute to the flexible spending accounts (FSAs) by making deposits to your FSAs (both your HCFSA and your DCFSA) through payroll deductions from your before-tax 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.

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 biweekly-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.

Plan carefully, however, because both types of FSA are subject to the IRS' "use it or lose it" rules. See "Flexible Spending Account (FSA) Limitations" on page 271 for more information.

Modifications to the "Use It Or Lose It" Rule for HCFSA

Any money in excess of $500 remaining in your HCFSA 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. For DCFSA, any unused balance amount will be forfeited at the end of the plan year. However, there is a three-month "run-out" period that ends on March 31 of the following Plan year, during which you can submit claims for eligible services rendered in the prior year.

Changing Your Annual Contribution Amount

Health Care Flexible Spending Account (HCFSA)

Normally, you may not change the amount you contribute to your Health Care Flexible Spending Account (HCFSA) or stop payroll deductions mid-year. However, you may be able to increase or decrease your current HCFSA annual contribution goal during the year 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 "What Happens..." on page 283.)

Dependent Care Flexible Spending Account (DCFSA)

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 "What Happens..." on page 283.

You may also make a corresponding change to your Dependent Care Flexible Spending Account (DCFSA) 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 DCFSA 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 DCFSA would be allowed. Similarly, 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 DCFSA 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).

Health Care Flexible Spending Account (HCFSA)

You use the money in your Health Care Flexible Spending Account (HCFSA) 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 HCFSA.

The first step you should take when your enrollment in HCFSA becomes effective is to log in to your FSA Account. (This is the same log-in process you use for accessing a DCFSA as well.)

If you are an Anthem member or you have waived PG&E-sponsored medical coverage	If you are a KPIC member
▪ Go to http://www.yourspendingaccount.com/pge. ▪ Select the log-on link. ▪ If you are a new participant, choose Register as a New User to create 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 details are available at any time online, or over the phone at 800-964-9902.	▪ Go to kp.org/healthpayment. ▪ Sign in with your user ID and password. ▪ If you are a new participant, choose Register for a User ID and password. ▪ Once logged in, you can easily access your account balance, enter a new claim and view the reimbursement schedule. Your account details are available at any time online, or over the phone at 877-750-3399.

Three Ways to Pay for Eligible Health Care Expenses

Approach One: Automatic Reimbursement

If you are an Anthem member	If you are a KPIC member
▪ **Approach One: Automatic Reimbursement** is not available to you. Refer to **Approach Two: Use Your Health Care Debit Card** and **Approach Three: Pay for the Expense and File a Claim** for more details.	▪ Any coinsurance or deductible liability that you have incurred will automatically be processed by Kaiser Health Payment Services; and ▪ If you have sufficient credits in your HCFSA, Kaiser Health Payment Services will automatically pay your provider and you do not have to process any payments.

KPIC members can turn off this automatic payment feature any time in the calendar year. However, once turned off, it cannot be turned on again until the next calendar year. If you do turn off this feature, you will have to file a claim (outlined below). You must call Kaiser Health Payment Services at 877-750-3399 in order to turn off the automatic payment feature for each benefit plan year.

Approach Two: Use Your Health Care Debit Card

You'll automatically receive a health care debit card in the mail when you enroll in the Health Care Flexible Spending Account (HCFSA). You'll receive a single card even if you're enrolled in more than one account (e.g, HCFSA and Health Account). The card is not available for the Dependent Care Flexible Spending Account (DCFSA).

If you are an Anthem member or you have waived PG&E-sponsored medical coverage	If you are a KPIC member
▪ Your Spending Account (YSA) will mail you a YSA Card. ▪ Activate your card by following the instructions provided. ▪ Your card can be used for medical, dental and vision expenses, prescription drugs and mental health and substance abuse treatment. Your debit card is programmed to work only at providers whose primary business is to provide health care or health care-related products. ▪ Visit www.yourspendingaccount.com/pge for a list of expenses and locations where you can use your health care debit card.	▪ Kaiser Permanente Insurance Company will mail you a Health Payment Card. ▪ Activate your card by following the instructions provided. ▪ Your card can only be used for prescription drug purchases. It is programmed to work only at Kaiser Permanente retail pharmacies, the Kaiser Permanente mail-order pharmacy, and some participating non-Kaiser Permanente pharmacies. Participants should use the card at Kaiser retail pharmacies and the Kaiser mail-order pharmacy to receive benefit coverage. ▪ Visit kp.org/healthpayment for a list of expenses and locations where you can use your health care debit card.

The available balance on your card will reflect your total annual HCFSA contribution amount, minus any claims that have been paid. This amount is available right away, even before you've made all your annual contributions.

If you have more than one account, the available balance on your card will reflect the total available for all accounts. When you swipe your health care debit card, the system makes sure that your account is active and that you have sufficient funds for the full amount. If not, the transaction will be denied. As an alternative, you can swipe the card for the amount left in your account and pay the difference with another form of payment, or you can pay out of pocket and file a claim for reimbursement.

Be sure to keep your itemized receipts as documentation, including 1) patient's name, 2) date of service, 3) provider's name, 4) description of services rendered, and 5) amount you owe. Although your health care debit card eliminates the need to file paper claims for prescription drugs and (for Anthem HAP members) medical services, your charges must be verified. **Always keep your receipts for tax purposes, in case Your Spending Account (YSA) or Kaiser Health Payment Services or the IRS needs to confirm a purchase**. Your Spending Account (YSA) or Kaiser Health Payment Services will notify you within approximately a week from the date of your health care debit card swipe if a receipt is needed. If Your Spending Account (YSA) or Kaiser Health Payment Services has your e-mail information, notification will be electronic. Otherwise, it will be by mail. If you use the health care debit card for an ineligible expense or an expense for which Your Spending Account (YSA) or Kaiser Payment Account Services does not have proper documentation, you will be required to reimburse the account for the amount of that transaction.

If you need to order a replacement or additional health care debit card, you can log on to your online account or call Your Spending Account (YSA) at 800-964-9902 or Kaiser Health Payment Services at 877-750-3399 to request another card. Be sure to call as well if your card is lost or stolen.

For details on how to use your health care debit card and more information about how to submit expenses, contact your account administrator. If you are an Anthem member or waived PG&E-sponsored medical coverage, contact Your Spending Account (YSA) by logging in at www.yourspendingaccount.com/pge or by calling 800-964-9902 If you are a KPIC member, log in at kp.org/healthpayment.

Approach Three: Pay for the Expense and File a Claim

You can also pay for out-of-pocket expenses using your own personal credit or debit card, cash or check, and keep your itemized receipt as documentation. Then, log in to your online account to file for reimbursement. For KPIC members, this option applies when you:

- have opted out of the Automatic Reimbursement feature;
- are paying for services not covered under the HAP; or
- have depleted the funds in your Health Account.

Here's how 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. **Then log in to your online account to file for a reimbursement and submit your supporting documentation** (e.g., itemized receipt or EOB), by uploading, faxing, or mailing them to the administrator. If you are an Anthem member or have waived PG&E-sponsored medical coverage, go to www.yourspendingaccount.com/pge and select the log-in link or use YSA's **Reimburse Me** smartphone app. If you are a KPIC member, go to kp.org/healthpayment and enter your user ID and password. Follow the prompts to file a claim. You can also use Kaiser's smartphone app—**KP HRA/HSA/FSA Balance Tracker**. Both YSA and Kaiser's smartphone apps are available through the iTunes app store and the Google Play Android store.

If you need help determining which of your expenses are eligible, you should contact Your Spending Account (YSA) or Kaiser Health Payment Services. Eligibility for reimbursement is based on when services are actually received, regardless of when you pay for such expenses.

Print and mail the completed claim submission form, along with original invoices, receipts, EOBs, or health plan website claims print-outs to:

If you are an Anthem member or you have waived PG&E-sponsored medical coverage	If you are a KPIC member
Your Spending Account (YSA) P.O. Box 785040 Orlando, FL 32878-5040	Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540

Be sure to keep a photocopy of everything for yourself before you submit it to the Your Spending Account (YSA) or Kaiser Health Payment Services processing center. Or you may fax your completed claims submission form and a copy of the original invoices to 888-211-9900 if you are an Anthem member or have waived PG&E-sponsored medical coverage or 877-535-0821 if you are a KPIC member. Save a copy of your fax confirmation receipt as proof of successful submission.

For details on using your HAP credits, see the *Health Account* section.

Processing of Manual Claims

Claims are processed daily. If you are in the Anthem HAP or have waived PG&E-sponsored medical coverage, after your claim is processed, you'll receive a reimbursement check mailed to your home, or you can elect direct deposit into your bank account at **www.yourspendingaccount.com/pge**. If you choose automatic deposit for your FSA reimbursements for any calendar year, the election will automatically roll over when you re-enroll in the Plan for a future year. If you are in the KPIC HAP, your provider will automatically be paid if you have enough funds in your account. Reimbursement checks issued to you and not cashed within six (6) months of issuance will be considered forfeitures.

How to Avoid Overpayment

When you pay for health care expenses at the doctor, pharmacist, hospital, dentist, or eye doctor, always present your health insurance ID card first to ensure your claims are filed correctly.

You'll usually be required to pay for prescriptions upfront before you receive the prescription. However, for other types of expenses, don't pay right away. Instead, wait until your claim is processed and you receive your Explanation of Benefits (EOB). This helps avoid overpayment. Compare your EOB with the provider bill to verify the amount being charged by your provider is the same as the patient balance on the EOB. You then may pay using your health care debit card, your own personal credit/debit card, cash or check and then request reimbursement online.

Always Save Your Itemized Receipts

Always save your itemized receipts regardless of how you pay. You're responsible for ensuring your withdrawals are for IRS-approved expenses. You'll need your receipts to verify your expenses were eligible if you're ever audited. The IRS may require documentation to show the money was used for qualified expenses. Be sure your receipts have all of these details:

- Date
- Name and address of the provider or merchant
- Description of the service provided or product purchased
- Amount charged

Health care debit card or credit card receipts, non-itemized cash register receipts, and cancelled checks are insufficient. Please be sure you have a doctor's prescription for any over-the-counter medicines you purchase, as the eligibility of over-the-counter items depends on whether you have a prescription. For updated information, visit www.yourspendingaccount.com/pge if you are an Anthem member or have waived PG&E-sponsored medical coverage or kp.org/healthpayment if you are a KPIC member.

If requested by Your Spending Account (YSA) or Kaiser Health Payment Services, please be sure to provide your health care debit card receipts within the time frame requested. Otherwise, your payment or swipe transaction will be deemed ineligible and you will be required to refund the amount of transaction. If you fail to submit required receipts, your debit card will be deactivated. In addition, if you fail to reimburse your account, the total amount of the ineligible expenses may be added to your W-2 as taxable income.

Deadline for Submitting Health Care Claims and Receipts

There is a three-month "run-out" period that ends March 31 of the following plan year during which you can submit and provide supporting documentation to substantiate claims for eligible services rendered in the prior year. For example, you have until March 31, 2015 to submit claims for eligible health care expenses incurred through December 31, 2014, provided funds have not already been exhausted. In accordance with IRS restrictions:

- any amount over $500 remaining in a HCFSA after March 31 will be forfeited (amounts of $500 or less will automatically roll over to the following year); and
- any money remaining in a DCFSA after March 31 will be forfeited.

Dependent Care Flexible Spending Account (DCFSA)

You use the money in your Dependent Care Flexible Spending Account (DCFSA) 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 DCFSA.

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

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.

If you are an Anthem member or you have waived PG&E-sponsored medical coverage	If you are a KPIC member
▪ Go to www.yourspendingaccount.com/pge. ▪ Once logged on, you can easily access your account balance, enter a new claim and view the reimbursement schedule. Your account details are available at any time online, or over the phone at 800-964-9902.	▪ Go to kp.org/healthpayment. ▪ Once logged on, you can easily access your account balance, enter a new claim and view the reimbursement schedule. Your account details are available at any time online, or over the phone at 877-750-3399.

If you need help determining which of your expenses are eligible, you should contact Your Spending Account (YSA) or Kaiser Health Payment Services, as applicable. Eligibility for reimbursement is based on when services are actually received, regardless of when you pay for such expenses. See Eligible Expenses" on page 279 for further details.

You can print and mail the completed claim submission form, along with original invoices or receipts to the Your Spending Account (YSA) or Kaiser Health Payment Services processing center. Be sure to keep a photocopy of everything for yourself before you submit it to the Your Spending Account (YSA) or Kaiser Health Payment Services processing center. Or you may fax your completed claims submission form and a copy of the original invoice. Save a copy of your fax confirmation receipt as proof of successful submission.

If you are an Anthem member or you have waived PG&E-sponsored medical coverage, submit documentation to	If you are a KPIC member, submit documentation to
Your Spending Account (YSA) P.O. Box 785040 Orlando, FL 32878-5040 Fax number;: 888-211-9900 www.yourspendingaccount.com/pge	Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540 Fax number: 877-535-0821 kp.org/healthpayment E-mail: kp@healthaccountservices.com

Processing of Claims

If you are in the Anthem HAP or have waived PG&E-sponsored medical coverage, after your claim is processed, you'll receive a reimbursement check mailed to your home, or you can elect direct deposit at **www.yourspendingaccount.com/pge**. Reimbursement checks issued and not cashed within six (6) months of issuance will be considered forfeitures. If you choose automatic deposit for your FSA reimbursements for any calendar year, the election will automatically roll over when you re-enroll in the Plan for a future calendar year.

If you are a KPIC member, log in to kp.org/healthpayment.

Always Save Your Itemized Receipts

Always save your itemized receipts regardless of how you pay. The IRS may require documentation to show the money was used for qualified expenses. Be sure your receipts have all of these details:

- Date of service
- Dependent's name
- Service provider's name

- Service provider's tax ID (or Social Security number if the provider is not registered or licensed with the state, even if the provider is someone such as your neighbor)
- Description of the service
- Amount charged

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

Deadline for Submitting Dependent Care Claims and Supporting Documentation

There is a three-month "run-out" period that ends March 31 of the following plan year during which you can submit and provide supporting documentation to substantiate claims for eligible services rendered in the prior year. For example, you have until March 31, 2015 to submit claims for eligible dependent care expenses incurred through December 31, 2014, provided funds have not already been exhausted. In accordance with IRS restrictions, any money remaining in the account after March 31 will be forfeited.

When Reimbursements Are Available

For the Health Care Flexible Spending Account (HCFSA), 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 Dependent Care Flexible Spending Account (DCFSA) claims, the amount of the reimbursement will depend upon how much money is in your account. You will be reimbursed in full for your incurred 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.

Flexible Spending Account (FSA) Limitations

Flexible spending accounts (FSAs) 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, divorce, etc.
- 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 (180 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 Flexible Spending Account (HCFSA) goal. See "What Happens..." on page 283.
- If you have both an HCFSA and a DCFSA, 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, except for up to $500 of your HCFSA, which will automatically roll over (see below). Any other money left in either of your FSAs after all expenses for the Plan Year have been submitted is, under tax law, forfeited. You cannot carry any other unused money forward into the next year.

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

The IRS has modified the "use it or lose it" rule for Health Care Flexible Spending Accounts (HCFSAs). In the 2013 plan year and going forward, up to $500 of any unused balance will be automatically carried over from one plan year to the next. The carryover amount does not impact the annual HCFSA federal contribution limit of $2,500.

What this means to you

If you have funds left in your HCFSA at the end of the year, up to $500 will automatically carry over into an HCFSA to be used for eligible expenses incurred in the new plan year. Any funds above $500 left in your account will not carry over for use in the new year and will be forfeited.

When will my carry-over FSA dollars be available?

You have until March 31 of the following plan year to submit claims for eligible services rendered in the prior plan year. After all prior year claims have been processed, your remaining balance, up to $500, will automatically carry over into an HCFSA and be available to pay for eligible health care expenses incurred in the new plan year for you or your IRS-qualified dependents.

Examples:

If your 2013 plan year HCFSA remaining balance is $500 or less at the end of the run-out period on March 31, 2014, the entire amount will carry over to the next plan year for your 2014 health care expenses, whether or not you make a 2014 HCFSA election. For example, if your 2014 HCFSA election is $2,500, you will have access to a total of up to $3,000 ($2,500 annual goal + up to $500 carryover) in a HCFSA balance. If you did not elect a 2014 HCFSA, you will still have up to a $500 HCFSA balance for 2014 health care expenses. The HCFSA carryover amount will not be forfeited, unless you lose eligibility.

If your 2013 plan year HCFSA remaining balance is $700 at the end of the run-out period on March 31, 2014, $500 will carry over to the next plan year for your 2014 health care expenses, whether or not you make a 2014 HCFSA election. The remaining $200 will be forfeited. If your 2014 HCFSA election is $2,500, you will have access to a total of $3,000 ($2,500 annual goal + $500 carryover) in a HCFSA balance. If you did not elect a 2014 HCFSA, you will still have a $500 HCFSA balance for your 2014 health care expenses. The HCFSA carryover amount will not be forfeited, unless you lose eligibility.

Questions About Claims for Reimbursement

You should refer any questions about your claims for reimbursement to the Claims Administrator: Your Spending Account (YSA) if you are an Anthem member or have waived PG&E-sponsored medical coverage, or Kaiser Health Payment Services if you are a KPIC member. If you have questions after reviewing the website, please contact Anthem or Kaiser Health Payment Services, as applicable.

If you are an Anthem member or you have waived PG&E-sponsored medical coverage	If you are a KPIC member
Your Spending Account (YSA) 800-964-9902 Service hours: 5 a.m. to 5 p.m., Pacific time, Monday through Friday Mailing address: Your Spending Account (YSA) P.O. Box 785040 Orlando, FL 32878-5040 www.yourspendingaccount.com/pge	Kaiser Health Payment Services 877-750-3399 Service hours: 5 a.m. to 7 p.m., Pacific time; Monday through Friday Mailing address: Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540 kp.org/healthpayment E-mail address: kp@healthaccountservices.com

Health Care Flexible Spending Account (HCFSA)

Eligible Expenses

Eligible expenses are defined by the IRS and typically cover most treatments or services used in preventing an illness or improving a medical condition. For example, most health care expenses not covered or not paid in full by a health care plan, including deductibles, coinsurance, or out-of-pocket expenses for prescription drugs and out-of-network services, are eligible expenses. To be eligible for reimbursement, the service must be received during the period in which you have contributed to an HCFSA (except for the last $500 remaining in your HCFSA each year, which can be rolled over and used for eligible expenses in the following plan year). 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). Refer to the IRS Publication 502, Medical and Dental Expenses, available from your local IRS office (or the IRS website at www.irs.gov) for more details on eligible health care expenses. Use IRS Publication 502 with caution, as it is meant only to help taxpayers determine what medical expenses can be deducted on their personal income tax returns and not what is reimbursable under a health care FSA. Contact your Claims Administrator if you need further information about which expenses are reimbursable.

For KPIC Members Only

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

If you have an enrolled domestic partner under HAP who does not qualify as a dependent under Internal Revenue Code Section 152, you must turn off the automatic reimbursement process under the Health Care FSA in order to comply with IRS regulations concerning reimbursement for non-eligible dependents. Please call Kaiser Health Payment Services at 877-750-3399 to turn off the automatic reimbursement option.

Ineligible Expenses

You cannot use your Health Care Flexible Spending Account (HCFSA) for any expenses paid for by any other medical, dental or vision plans, for any expense that is not considered tax-deductible by the IRS, or for anything that is not considered an eligible health care item. Refer to the IRS Publication 502, Medical and Dental Expenses, available from your local IRS office, or the IRS website at www.irs.gov for more details on ineligible health care expenses.

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. If you have questions about how claims for ongoing treatment programs will be reimbursed, contact Your Spending Account (YSA) at 800-964-9902 or www.yourspendingaccount.com/pge if you are an Anthem member or have waived PG&E-sponsored medical coverage, or Kaiser Health Payment Services at 877-750-3399 or kp.org/healthpayment if you are a KPIC member.

Claims and Appeals

If Eligibility Is Denied

To participate in a benefit plan, you and your dependents must meet the eligibility requirements and enroll or change your enrollment in the time frames specified by the plan. Before filing an eligibility appeal, you may call the HR Service Center first to see if the eligibility issue can be resolved informally.

If you are not satisfied with the outcome of your contact with the HR Service Center, you may file an eligibility claim with the Plan Administrator by writing to:

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

If the Benefits Department denies your claim, you will receive written notice of the denial within 60 days of receipt of the initial claim unless, due to special circumstances, an additional 60 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; and
- a description of the Plan's review procedures and the time limits applicable to such procedures.

Eligibility Appeals

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 decision maker in the appeals process, stating the reasons for your appeal and enclosing all documentation and any additional information to support your appeal.

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.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
1850 Gateway Blvd., 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; 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.

Health Care Flexible Spending Account Claims

If a Health Care Flexible Spending Account (HCFSA) claim you submit is denied in part or whole, YSA or Kaiser Health Payment Services, as the 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 on which the Claims Administrator received your claim.

Send your claims to:

If you are an Anthem member or you have waived PG&E-sponsored medical coverage	If you are a KPIC member
Your Spending Account (YSA) P.O. Box 785040 Orlando, FL 32878-5040	Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540

If YSA or Kaiser Health Payment Services need 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.

Health Care Flexible Spending Account (HCFSA) Appeals

If you believe the initial determination denies you a Health Care Flexible Spending Account (HCFSA) benefit to which you may be entitled, you may appeal to the Plan Administrator.

Send your first appeal to:

If you are an Anthem member or you have waived PG&E-sponsored medical coverage	If you are a KPIC member
Your Spending Account (YSA) P.O. Box 785040 Orlando, FL 32878-5040	Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540

This appeal must be made in writing within 180 days after receiving written notice of the denial from YSA if you are an Anthem member or have waived PG&E-sponsored medical coverage, or from Kaiser Health Payment Services if you are a KPIC member. The appeal 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).

To expedite processing, you should also include a HIPAA AUTHORIZATION TO USE AND/OR DISCLOSE PERSONAL HEALTH INFORMATION form. You can access a copy online from the **Human Resources Forms** section of the PG&E@Work intranet site or by calling the HR Service Center at 415-973-4357 or toll-free at 800-788-2363.

YSA or Kaiser Health Payment Services will generally make a decision within 60 days after receiving the appeal and mail or email a copy of the decision to you promptly. The decision will either overrule or uphold the Plan Administrator's earlier determination, based on plan parameters and guidelines received from PG&E. The decision will give specific reasons and references to the HCFSA Plan provisions which support the YSA's or Kaiser Health Payment Service's decision.

PG&E's Voluntary Claims and Appeals Review Process

If you are not satisfied with the claims and appeals review process completed with YSA or KPIC, as applicable, you may elect to use PG&E's Voluntary Claims and Appeals Review Process, as described below, or elect to bring a civil action. You have 90 days from the date of receipt of the final decision from YSA or KPIC to elect this claims and appeals review process. Initiation of the Voluntary Claims and Appeals Review Process does not restrict your ability to bring a civil action against the Plan.

The first step of the Voluntary Claims and Appeals Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include a HIPAA AUTHORIZATION TO USE AND/OR DISCLOSE PERSONAL HEALTH INFORMATION form. You can access a copy online from the **Human Resources Forms** section of the PG&E@Work intranet or by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Send your appeal to:

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

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the HIPAA Authorization may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial;
- a reference to the Plan provision(s) which apply to the denial; and
- an explanation of additional appeals procedures.

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

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

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

- the specific reason(s) for the denial;
- 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.

Dependent Care Flexible Spending Account (DCFSA)

The Dependent Care Flexible Spending Account (DCFSA) helps you pay to care for dependents so you can work.

The DCFSA is not for your dependents' health care. It is for care such as day care or elder care.

Whose Expenses Are Eligible?

The definition of a Dependent Care Flexible Spending Account (DCFSA) 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 Flexible Spending Account (HCFSA). The following table lays out the requirements for the three types of DCFSA Dependents. To be considered a Dependent for DCFSA 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 DCFSA Dependent, and you may not be reimbursed for his or her expenses.

The three categories of DCFSA Dependents are:

- Column A: your children and other relatives.
  - Most people use the DCFSA for day care 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 DCFSA 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 DCFSA Dependent. See Column C for these requirements.

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.

Requirements	A	B	C
	If the person satisfies every requirement in this column, he or she is a DCFSA Dependent. **If the person fails to satisfy 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 DCFSA Dependent.** **If the person fails to satisfy 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 DCFSA Dependent.** **If the person fails to satisfy any one or more of these requirements, try Column A or B.**
Relationship requirement	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	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	None Dependent is not required to be related to you under Column C.
Residency requirement	You and Dependent must have the same primary residence for more than half the year	You and Dependent must have the same primary residence for more than half the year	You and Dependent must have the same primary residence for the entire year
Support requirement	Dependent may not provide more than half of his or her own support	You must provide more than half the Dependent's support	You must provide more than half the Dependent's support

Requirements	A	B	C
	If the person satisfies every requirement in this column, he or she is a DCFSA Dependent. **If the person fails to satisfy 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 DCFSA Dependent.** **If the person fails to satisfy 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 DCFSA Dependent.** **If the person fails to satisfy any one or more of these requirements, try Column A or B.**
Age and disability requirement	Dependent must be less than 13 years old	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 Dependent Care Flexible Spending Account (DCFSA) 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 DCFSA 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 DCFSA 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 DCFSA. 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 Are Eligible?
- 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.

Tax Credits

The Dependent Care Flexible Spending Account (DCFSA) 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 DCFSA 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 DCFSA and the Federal Dependent Care Income Tax Credit, but not for the same expenses. In other words, if you open a DCFSA, 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 DCFSA to pay for expenses not used in figuring your tax credit.
- Every dollar that you contribute to the DCFSA 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.

Consult Your Tax Advisor

As tax savings of the Dependent Care Flexible Spending Account (DCFSA) 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).

If Eligibility Is Denied

To participate in a benefit plan, you and your dependents must meet the eligibility requirements and enroll or change your enrollment in the time frames specified by the plan. Before filing an eligibility claim, you may call the HR Service Center first to see if the eligibility issue can be resolved informally.

If you are not satisfied with the outcome of your contact with the HR Service Center, you may file an eligibility claim with the Plan Administrator by writing to:

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

If the Benefits Department denies your claim, you will receive written notice of the denial within 60 days of receipt of the initial claim unless, due to special circumstances, an additional 60 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; and
- a description of the Plan's review procedures and the time limits applicable to such procedures.

Eligibility Appeals

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 decision maker in the appeals process, stating the reasons for your appeal and enclosing all documentation and any additional information to support your appeal.

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.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
1850 Gateway Blvd., 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:

- a 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.

Dependent Care Flexible Spending Account (DCFSA) Claims

If a Dependent Care Flexible Spending Account (DCFSA) claim you submit is denied in part or whole, YSA or Kaiser Health Payment Services, as the 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 claims to:

If you are an Anthem member or you have waived PG&E-sponsored medical coverage	If you are a KPIC member
Your Spending Account (YSA) P.O. Box 785040 Orlando, FL 32878-5040	Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540

Dependent Care Flexible Spending Account (DCFSA) 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 first appeal to:

If you are an Anthem member or you have waived PG&E-sponsored medical coverage	If you are a KPIC member
Your Spending Account (YSA) P.O. Box 785040 Orlando, FL 32878-5040	Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540

This appeal must be made in writing within 180 days after receiving written notice of the denial from YSA if you are an Anthem member or have waived PG&E-sponsored medical coverage, or Kaiser Health Payment Services if you are a KPIC member, 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).

To expedite processing, you should also include a HIPAA AUTHORIZATION TO USE AND/OR DISCLOSE PERSONAL HEALTH INFORMATION form. You can access a copy online from the **Human Resources Forms** section of the PG&E@Work intranet site or by calling the HR Service Center at 415-973-4357 or toll-free at 800-788-2363.

YSA or Kaiser Health Payment Services will generally make a decision within 60 days after receiving the appeal and mail or email a copy of the decision to you promptly. The decision will either overrule or uphold the Plan Administrator's earlier determination, based on plan parameters and guidelines received from PG&E. The decision will give specific reasons and references to the HCFSA Plan provisions which support YSA's or Kaiser Health Payment Service's decision.

PG&E's Voluntary Claims and Review Process

If you are not satisfied with the claims and appeals review process completed with YSA or KPIC, as applicable, you may elect to use PG&E's Voluntary Claims and Appeals Review Process, as described below. You have 90 days from the date of receipt of the final decision from YSA or KPIC to elect this claims and appeals review process. Initiation of the Voluntary Claims and Appeals Review Process does not restrict your ability to bring a civil action against the Plan.

The first step of the Voluntary Claims and Appeals Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include a HIPAA AUTHORIZATION TO USE AND/OR DISCLOSE PERSONAL HEALTH INFORMATION form. You can access a copy online from the **Human Resources Forms** section of the PG&E@Work intranet or by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Send your appeal to:

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

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the HIPAA Authorization may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial;
- a reference to the Plan provision(s) which apply to the denial; and
- an explanation of additional appeals procedures.

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

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

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

- the specific reason(s) for the denial;
- a 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.

What Happens…

If You Take a Leave of Absence Without Pay

Health Care Flexible Spending Account (HCFSA)

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 Health Care Flexible Spending Account (HCFSA). Whether you elect to continue or cancel your contributions, you must complete a Health Care Flexible Spending Account (HCFSA) Election While on Unpaid Leave of Absence form and return it to the HR Service Center within 15 days of receipt. If the Election form is not received, your HCFSA will be automatically cancelled the first day of the month following your unpaid leave start date.

Health Care Flexible Spending Account (HCFSA) Elections While on an Unpaid Leave of Absence

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.

Your Health Care Flexible Spending Account (HCFSA) 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 HCFSA, 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 × $100 = $300, plus 6 × $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 an HCFSA until the next Open Enrollment period, unless you have an eligible change in status.

Health Care Spending Account (HCFSA) Elections During Open Enrollment

If your unpaid 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 Health Care Flexible Spending Account (HCFSA) contributions while on leave during the new calendar year.

If you elected to contribute to an HCFSA during Open Enrollment, you will be sent an election form on which you must indicate whether or not you wish to contribute to your HCFSA 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 HCFSA 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 HCFSA 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 an HCFSA 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 Flexible Spending Account (DCFSA)

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 Flexible Spending Account (DCFSA) 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 flexible spending 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 the Health Care Flexible Spending Account (HCFSA) or Dependent Care Flexible Spending Account (DCFSA). If you are on Workers' Compensation, during the annual Open Enrollment period you may not elect to contribute to an HCFSA unless you are also on an FMLA leave (See the *Time Off and Leaves* section for a description of FMLA leaves) and you may not contribute to DCFSA. To continue your HCFSA contributions while on Workers' Compensation, you must contact the HR Service Center at 415-973-4357 or toll-free at 800-788-2363.

If You Retire or Leave the Company

Monthly contributions to the Dependent Care Flexible Spending Account (DCFSA) will stop at the earlier of the end of the month in which you die or otherwise leave the Company. If you retire monthly contributions will stop at the end of the month prior to your retirement

You may continue your Health Care Flexible Spending Account (HCFSA) contributions until the end of the current year on an after-tax basis if participation is continued through COBRA (see "Continuing Coverage under COBRA" in the *Participating in Health Care Benefits* section). 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 HCFSA through COBRA in the year following your termination or retirement.

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 and supporting documentation 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, except for up to $500 of a HCFSA.

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

If you have more than one health care account — such as a Health Account and a Health Care Flexible Spending Account (HCFSA) — there are special rules governing the order in which the accounts can be used to cover eligible expenses. Your administrator will automatically debit the correct amount from each account.

If You Have Both a Health Care Flexible Spending Account (HCFSA) and a Health Account

If you participate in both the HCFSA and the Health Account, your health care debit card, as well as the auto reimbursement process (Kaiser members only), is programmed to deduct money first from your HCFSA to help you avoid forfeiting unused amounts at the end of the year. After you use all the money in your HCFSA, money will automatically then be drawn from your Health Account. Remember, only $500 from a HCFSA can be rolled over each year, while balances in your Health Account roll over year after year, as long as one of the following occurs:

- You remain enrolled in the Health Account Plan (HAP), whether as an active employee or through COBRA;
- You retire with eligibility for PG&E's retiree medical coverage; or
- You go on Long-Term Disability and remain enrolled in a PG&E medical plan.

Provision	HCFSA	Health Account
Types of eligible expenses you can incur	All IRS Section 213(d) eligible health care expenses	All IRS Section 213(d) eligible health care expenses
When you can start incurring eligible expenses	▪ January 1 of the year for which you open the account, if you enroll during the Open Enrollment period ▪ The date your coverage is effective, if you enroll midyear	**The IRS prohibits you from filing claims for expenses you incur before your Health Account has been established.** You'll be able to incur eligible expenses on or after the date your Health Account is established, **not before**.
How you can pay for eligible expenses	▪ Automatic reimbursement process for KPIC members (unless you turn off the automatic reimbursement feature through Kaiser Health Payment Services) ▪ Your YSA debit card (for Anthem HAP members) ▪ Your Kaiser debit card (for Kaiser HAP members): for pharmacy purchases only ▪ Your own personal credit card, cash or check ▫ You'll need to file a claim for reimbursement	

Sick Leave & Disability

In general, all full-time and part-time employees of the Company are eligible for the sick leave and disability plans described in this section. Contract and agency workers and hiring hall employees are not eligible for the benefits described in this section.

"Company" Defined

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

Resources to Help You Stay At or Return to Work

Pursuant to the federal Americans with Disabilities Act Amendments Act (ADAAA) and state Fair Employment and Housing Act (FEHA), if you are an eligible employee and need assistance to perform one or more essential functions of your job, you may request a reasonable accommodation. When a request for reasonable accommodation is received, the company will engage in the interactive process, which includes a discussion with the employee requesting the accommodation, supervisor, and the interactive process consultant, to determine how the requested accommodation, or a comparable accommodation, can be provided.

A reasonable accommodation is defined as the removal of a workplace barrier and would include any modification or adjustment to a job, employment practice or work environment that allows the eligible employee to perform the essential functions of the job and is not considered burdensome to a company.

Each accommodation request is reviewed and analyzed on a case-by-case basis to determine eligibility, effectiveness and reasonability of the accommodation in enabling the individual to perform the essential functions of his or her job. While the employee's accommodation preference will be considered during the interactive process, the company may offer an alternate accommodation if it removes the barrier and allows the employee to perform the essential functions of the job.

If you need to request a reasonable accommodation, you should discuss it with your supervisor and/or contact the Accommodations Team. Additional information can be reviewed on the **Reasonable Accommodations and the Interactive Process** section of the PGE@Work Intranet.

Additional Information

In addition to the information in this section, there is also important information about your benefits in other parts of this Handbook. Be sure to review the *About this Handbook* section, the *Benefits at a -Glance* section, the *What If...* section, and the *Rules, Regulations & Administrative Information* section.

Plan Documents and Administration

The plan documents and the most recent group long-term disability insurance policy or policies contain the detailed provisions of the plans. If a conflict exists between these plan documents and the portions of this Summary of Benefits Handbook which pertain to these plans or any other communications or documents, the terms of these plan documents shall govern the operation of the plans.

The Employee Benefit Committee of PG&E Corporation is the Plan Administrator of the plans and has the discretionary authority to interpret and construe the terms of the plans, to resolve any conflicts or discrepancies between documents and to establish rules which are necessary or desirable for the administration of the plans. Notwithstanding the foregoing, the insurer has the authority to construe and interpret the terms of the insurance policy, the certificate of insurance or other similar documents which describe the terms and conditions of the disability insurance policy or policies. Nothing in the plan documents or any other communication or document is intended to provide any individual with a substantive right to long-term disability benefits that are not provided for in the long-term disability insurance policy or policies.

In This Section

The Coverage Available

As a regular full-time, part-time, or intermittent employee, you are eligible for disability coverage under three different types of plans:

- Company-sponsored plans,
- Legislated plans, and
- Plan for Supplemental Benefits.

The Company offers you these benefits when you are unable to work due to illness or disability for either a short-term or long-term duration. Each of the plans is described briefly here; complete details of each plan follow later in this section.

The Pacific Gas and Electric Company Plans	Legislated Plans	Pacific Gas and Electric Company Supplemental Benefits
▪ Sick Leave ▪ Long-Term Disability (LTD)	▪ California State Disability Insurance (SDI) ▪ Workers' Compensation	▪ Supplemental Benefits for Industrial Injury

- Sick Leave — Provides continuation of your full salary for periods of illness or non-work-related injury based on annual sick leave awards and how much unused sick leave you have accumulated from past years.
- Long-Term Disability (LTD) — Provides you with income replacement if you become disabled because of an accident or a long-term illness and you are unable to work. This benefit, when combined with certain other sources of income that may be payable after the disability occurs, will be equal to either 50% or 66⅔% of your basic monthly pay.

  There are three different plans under which you may qualify for LTD benefits, depending on when you become eligible for LTD benefits and/or when the onset of your disability begins or began. Detailed information for each of these plans is provided under "Long-Term Disability" in the *Disability* section.

  - Plan I: For employees who became eligible for LTD benefits prior to January 1, 2000.
  - Plan II: For employees who became eligible for LTD benefits on or after January 1, 2000, and the onset of your disability was prior to:
    - June 1, 2003 (if IBEW Clerical, ESC or SEIU), or
    - October 1, 2003 (if IBEW Physical).
  - Plan III: For employees whose onset of disability is on or after:
    - June 1, 2003 (if IBEW Clerical, ESC or SEIU), or
    - October 1, 2003 (if IBEW Physical).
- Legislated Plans — benefits paid in compliance with federal and state law:
  - California State Disability Insurance (SDI) — The State of California pays a temporary income benefit for non-occupational illness or injury.
  - Workers' Compensation — The Company pays benefits for industrial injury or illness.
- Supplemental Benefits for Industrial Injury —The Company pays a supplemental benefit, above Workers' Compensation disability income, if you sustain an injury or illness on the job and are entitled to Workers' Compensation temporary disability benefits.

Eligibility, Enrollment and Cost

Eligibility

As a regular-status full-time union-represented employee, you are eligible for the Sick Leave Program after you complete one year of service. As a regular-status part-time or intermittent union-represented employee, you are eligible for a prorated share of sick leave benefits after you complete one year of service.

All employees are eligible for Workers' Compensation benefits upon hire. All regular-status full-time, part-time and intermittent employees are automatically covered by the Long-Term Disability (LTD) Plan on the first day of the month following attainment of regular status. If you work in California, you are automatically enrolled in the California State Disability Insurance (SDI) Plan when you are hired (please visit the State's website at www.edd.ca.gov for additional information on SDI benefit eligibility). Contract and agency employees are generally not eligible for coverage through the Pacific Gas and Electric Company, but are covered by their contracting agency.

You are not eligible for the Sick Leave Program or Company-sponsored disability benefits if you are a contract or agency worker or a hiring hall employee.

Enrollment

When you meet the eligibility requirements, you are automatically covered by all of the sick leave and disability coverages described in this section.

Cost of Coverage

The Company pays the full cost of the Sick Leave Program, the Long-Term Disability Plan, Workers' Compensation and the Supplemental Benefits for Industrial Injury Plan. You pay for the cost of coverage for State Disability Insurance (SDI) through payroll deductions on an after-tax basis.

Sick Leave

The Sick Leave Program provides continued pay when you are temporarily unable to work because of a health care appointment, an illness or a non-work-related injury. The length of time you can receive sick leave pay depends on how long you have worked for the Company and how much sick leave you have used during that time.

The use of Sick Leave does not extend the maximum period of leave to which the employee may be entitled under the California Family Rights Act (CFRA) or the Family and Medical Leave Act (FMLA).

Earning Sick Leave

Full-Time Employees

The maximum amount of sick leave for which you are eligible depends upon your length of service with the Company. This amount is based on the number of calendar years you have continuously worked, not credited service as defined under the Company's Retirement Plan.

During Your First Ten Years of Service

Full-time employees are eligible for 80 hours (ten days) of sick leave with pay, upon attaining regular-status and completing one year of service. Thereafter, you will receive an annual allowance of current sick leave on each January 1 or on the first day you return to work each year. You must work in the calendar year to receive and use the annual allowance of current sick leave. During your first ten years of service, you are credited annually with 80 hours (ten days) of current sick leave.

You can carry over up to eight years of sick leave credits. The maximum sick leave accumulation during your first ten years of service is 640 hours (80 hours times eight years). This is in addition to your 80 hours of current sick leave.

After Ten Years of Service

In the year in which you complete ten years of service, you can qualify for an additional 160 hours (20 days) of sick leave. These additional hours are available only if you need them. To qualify for this additional sick leave, you must have accumulated at least 320 hours (40 days) of unused sick leave during the previous eight years. Eligibility is calculated by totaling your cumulative sick leave allowance less sick leave taken — up to a maximum of 80 hours (ten days) per year — for the previous eight years.

These additional 160 hours (20 days) are not carried over from year to year; however, they will be renewed on the first day of each succeeding calendar year provided you are at work, on paid sick leave, vacation, Workers' Compensation or on a leave of absence with pay on the last working day of the year. If you are not in an eligible status on the last working day of the year, your 160 hours will be renewed on the first day of your return to work. Employees who do not qualify in their tenth year have an opportunity to qualify each year thereafter under the formula.

The maximum number of sick leave hours allowable for eligible employees who have between ten and 20 years of service is 880 hours (including 640 hours of accumulated sick leave, 160 additional hours and 80 hours of current sick leave).

After 20 Years of Service

In the year in which you complete 20 years of service, you can qualify for 160 more hours (20 days) of sick leave credit, in addition to the current allowance of 80 hours (ten days) and the 160 additional hours (20 days) for employees with ten or more years of service. These additional hours are only available if you need them. The same formula that is used at ten years is used to determine if you qualify for the additional sick leave at 20 years (accumulation of unused sick leave during the previous eight years).

To qualify for this additional sick leave, you must have qualified for the additional sick leave available to employees who attain ten years of service.

These additional 160 hours (20 days) are not carried over from year to year; however, they will be renewed on the first day of each succeeding calendar year provided you are at work, on paid sick leave, vacation, Workers' Compensation or on a leave of absence with pay on the last working day of the year. If you are not in an eligible status on the last working day of the year, your 160 hours will be renewed on the first day of your return to work. Employees who do not qualify in their twentieth year have an opportunity to qualify each year thereafter under the formula.

The maximum number of sick leave hours allowable for eligible employees with 20 or more years of service is 1,040 hours (including 640 hours of accumulated sick leave allowance, 320 additional hours and 80 hours of current sick leave).

Part-Time Employees

The maximum amount of sick leave for which you are eligible depends upon your length of service with the Company. Sick leave is based on the number of calendar years the employee has continuously worked, not credited service as defined under the Company's Retirement Plan.

During Your First Ten Years of Service

Current sick leave is awarded after one year of service and attainment of regular status and at the beginning of every calendar year thereafter.

The amount of sick leave a part-time employee receives is prorated based on the number of actual hours the employee worked in the previous year compared to 2,080 work hours. Actual hours worked include paid sick leave, vacation, Workers' Compensation of less than 880 cumulative hours in a calendar year, and leaves of absence with pay.

Employees who change from full-time to part-time status during the year keep their accumulated sick leave. On the following January 1, they are awarded their annual sick leave on a prorated basis.

You can carry over up to eight years of sick leave credits.

Here is an example of how sick leave is prorated for part-time employees:

Carol is hired on the first day of the year and works 20 hours per week. For her first calendar year, she works 1,040 straight-time (ST) hours. Carol's sick leave allotment for the next calendar year will be:

1,040 ST hours worked / 2,080 work hours per year (ratio)	×	80 hours (full-time allotment)	=	40 hours

Here is an example of how sick leave is calculated for employees who switch from full-time to part-time status:

Mark is a full-time employee who received 80 hours of sick leave effective at the beginning of the calendar year and changed to part-time status working 20 hours per week effective July 1 of that year. Mark is entitled to keep the 80 hours of sick leave he already has for the rest of the year. However, his sick leave allowance for the next calendar year will be based on the ratio of straight-time hours he worked in the prior year compared to 2,080 hours. The hours he worked in the prior year are:

1040 ST hours worked (40 hrs × 26 weeks) + 520 ST hours worked (20 hrs × 26 weeks) = 1,560 hours

Therefore, Mark's sick leave allowance for the next calendar year will be:

1,560 hours worked / 2,080 work hours per year (ration)	×	80 hours (full-time allotment)	=	60 hours

After Ten Years of Service

Part-time and intermittent employees qualify for a proration of the additional sick leave hours that full-time employees are eligible to receive. Eligibility for additional sick leave is determined by subtracting sick leave used (up to a maximum of the total allotment per year) from sick leave allotted during each of the eight years prior to attaining ten years of service. If the remainder is more than half of the sick leave allotted, the employee is eligible for additional sick leave hours.

Awards of additional sick leave for part-time employees are prorated based on the ratio of months of prorated service accrued in the previous eight calendar years to the full-time equivalent of 96 months. This ratio is then multiplied by 160 hours to determine the amount of additional sick leave to be awarded.

Here is an example of how additional sick leave after ten years is calculated for part-time employees:

Lucy worked 20 hours per week for eight full calendar years. Therefore, Lucy had been allotted 40 hours of sick leave per year × 8 years (sick leave credits can be carried over up to 8 years), which equals 320 hours of sick pay. Lucy used a total of 120 hours of sick pay over the past 8 years (and no more than 40 hours in any given year), leaving 200 of the original 320 hours. Since 200 hours is more than one-half of 320, she qualifies for the additional hours.

The number of hours to which Lucy is entitled is determined by the following formula:

Number of Months of Prorated Service = 6 months per year × 8 years = 48 months Earned for the Last Eight Years				
48 months / 96 months (ratio)	×	160 hours (full-time allotment)	=	80 additional hours (Lucy's additional sick leave)

After 20 Years of Service

Part-time and intermittent employees are eligible for additional sick leave after 20 years of service.

To qualify for this additional sick leave, you must have qualified for the additional sick leave available to employees who attain ten years of service. The same formula is used to calculate additional sick leave after 20 years as the one used to calculate additional sick leave after ten years, except that the last eight years prior to the employee's 20 years of service are used in the calculations.

Family Sick Leave

The Family Sick Leave law allows a full-time or part-time employee to use up to 50% of his/her current paid sick time allowance and 50% of the additional sick time hours after 10 (or 20) years of service per year to attend to an ill child, spouse/registered domestic partner or parent. The paid sick time must be available in order to be used. For example, a full-time employee who receives 80 hours of current paid sick time annually is allowed to use up to 40 hours of the 80 hours of paid sick time in the calendar year to attend to family illnesses as long as a total of 40 hours of sick time is available. A full-time employee who is eligible for the 160 (or 320) hours of additional sick time after 10 (or 20) years of service is allowed to use up to 80 (or 160) hours of the 160 (or 320) hours of additional sick time in the calendar year to attend to family illnesses as long as a total of 80 (or 160) hours of additional sick time is available.

All standard conditions which currently govern sick leave usage by employees will apply to paid Family Sick Leave. The use of Family Sick Leave does not extend the maximum period of leave to which the employee may be entitled under the California Family Rights Act (CFRA) or the Family and Medical Leave Act (FMLA).

Sick Leave Bonus Vacation Award

In each of the first five calendar years of employment, full-time employees who have used 40 hours (five days) or less of paid or unpaid sick leave in the preceding year will receive one day (8 hours) of additional vacation time in the next year.

In the 10th year of service, and every five years thereafter, employees may qualify for up to 40 hours of additional vacation time based on sick leave usage. To qualify for this additional vacation, employees must have accumulated at least 200 hours (25 days) of sick leave. Eligibility is calculated by totaling the cumulative sick leave allowance less sick leave used — up to a maximum of 80 hours per year — for the previous five years.

Employees must be on active payroll and work in the year in which sick leave bonus vacation is awarded. Your sick leave bonus vacation hours will be available to you in the year in which you meet the service and sick leave usage requirements, provided you have worked one day in that year.

Part-time and intermittent employees should refer to their particular bargaining agreements for provisions regarding eligibility for sick leave bonus vacation awards.

If you have any questions concerning your sick leave or vacation usage, contact your department's timekeeper.

Using Sick Leave

- Time is charged against your sick leave accumulation when you miss work because of an illness, a non-work-related injury, a health care appointment, or when you attend to the illness of an eligible family member. Available sick leave must be used and exhausted prior to being unpaid or requesting other types of payment. Sick leave time is recorded in increments of 15 minutes or more. Your personal sick leave accounts are charged when you use one hour or more of sick leave.

Employees working part-time or on alternate work schedules will be charged with the same number of sick leave hours as the hours they are scheduled to work on the day sick leave is taken.

Employees who become sick or disabled while on vacation may request vacation days to be changed to sick leave by submitting satisfactory medical evidence to their supervisor within ten working days of returning to work. See "Illness While on Vacation" under the *Time Off Section* for additional information.

If you receive sick leave pay for time off which is later determined to have resulted from an industrial injury (for example, if you have a delayed or disputed claim), the sick leave charged for your absence may be restored up to an equivalent sum of Workers' Compensation benefits due.

If a holiday falls on a workday while you are receiving sick leave benefits, the day will be reported as a holiday and not as a sick leave day.

Using Sick Leave Appropriately

The Company may request a note from your doctor or other certification of illness or injury. The Company expects all employees to use sick leave only as necessary and reserves the right to take disciplinary action against any employee who abuses sick leave benefits. If an employee falsifies a sick leave claim, all sick leave payments related to the falsified claim must be repaid. If these offenses continue, the Company may cancel all or any part of current or cumulative sick leave credits and treat the offense as it would any other violation of a condition of employment.

Terminated Employees

Sick leave is not payable upon termination from employment unless you fall under one of the following categories:

- Employees who go on Long-Term Disability as a result of an accepted Workers' Compensation claim. These employees' sick leave balances remain on the books until termination. (Termination is defined as resignation, retirement or death.) Then, upon termination from Long-Term Disability, these employees are paid for their unused sick leave at the rate of pay on the last day worked.
- Employees who separate employment from the Workers' Compensation payroll because of disability. These employees will be paid for their unused sick leave at the rate of pay on the last day worked.

Employees who terminate and who are later rehired do not receive sick leave credit for prior service. Sick leave will be earned in the same manner as for new employees.

However, employees who have been laid-off and who are later re-employed within 30 months will receive sick leave credit for prior service. Employees who have been laid-off and who are later re-employed after 30 months will not receive sick leave credit unless their Company service, as defined in their Union Agreement or an applicable letter of agreement, is determined not to be broken. Sick leave will be earned in the same manner as for new employees.

Long-Term Disability (LTD) Plan

The LTD Plan provides you with a steady source of income if you become disabled because of an accident or a long-term illness. This benefit, when combined with certain other sources of income that may be payable after the disability occurs, will be equal to 50% or 66⅔% of your basic monthly pay.

As a regular full-time, part-time or intermittent employee of Pacific Gas and Electric Company, you are automatically eligible for coverage under the Company's Long-Term Disability (LTD) Plan. (You are not eligible for LTD coverage if you are a contract or agency worker or hiring hall employee.)

There are three different plans under which you may qualify for LTD benefits, depending on when you become eligible for LTD benefits and/or when your disability begins.

Plan I

Your LTD benefits will be provided according to the provisions of Plan I if you became eligible for LTD benefits prior to January 1, 2000.

This Plan provides a monthly income equal to 50% of your basic monthly rate of pay. Benefits begin after the benefit waiting period of six cumulative months of disability. Benefits may continue for a period of time based on your length of credited service at the time you became disabled. Detailed information on Plan I is available in this section.

Plan II

Your LTD benefits will be provided according to the provisions of Plan II if you became eligible for LTD benefits on or after January 1, 2000, and the onset of your disability was prior to:

- June 1, 2003 (if IBEW Clerical, ESC or SEIU), or
- October 1, 2003 (if IBEW Physical).

This Plan provides a monthly income equal to 66⅔% of your basic monthly rate of pay. Benefits begin after the benefit waiting period of six cumulative months of disability.

Your LTD benefit continues until age 65, provided that you continue to meet the qualifying criteria and your disability is not covered under the mental/nervous provisions explained later in this section under Plan II.

Plan III

Your LTD benefits will be provided according to the provisions of Plan III if your onset of disability begins on or after:

- June 1, 2003 (if IBEW Clerical, ESC or SEIU), or
- October 1, 2003 (if IBEW Physical).

This Plan provides a monthly income equal to 66⅔% of your basic monthly rate of pay. Benefits begin after the benefit waiting period of five consecutive months of disability. Your LTD benefit continues until age 65 provided that you continue to meet the qualifying criteria and you are receiving a Social Security disability benefit. Detailed information on Plan III is provided in this section under Plan III.

How Disability Is Determined

In general, you will be considered "disabled" if an illness or injury keeps you from performing the normal duties of your job and the Company is unable to place you in a job suited to your reduced work capabilities. Inability to work with a supervisor, co-worker, department or line of business is not generally considered to be a disability.

To be considered for LTD benefits, you must be off work due to a disability for the benefit waiting period and initiate the LTD process by calling the third-party LTD administrator, Matrix Absence Management Inc. (Matrix) at 888-445-4462.

Depending on the nature of your disability (industrial or non-industrial), you must submit the necessary forms along with any required medical records to the third-party LTD administrator before you can be approved for LTD benefits. When you contact the third-party LTD administrator, they will advise you of any timing requirements for applying for benefits.

Your application and medical certification of your disability will be reviewed for approval or denial of LTD benefits, within 45 days of receipt of your written LTD claim and medical evidence. If, due to insufficient information, a determination cannot be made within 45 days, the third-party LTD administrator may request up to two additional 30-day extensions. See *"*Claims and Appeals — Plans I, II and III*"* for additional information.

Medical Examinations

To determine your eligibility for disability benefits under the Plan, you are required to undergo a physical examination by the Qualified Medical Provider who was or is treating you for the disability for which you are applying for LTD benefits.

In order to verify your disability and/or at any time during your LTD benefit period, you may be required to undergo a physical examination performed by a Qualified Medical Provider selected by the Company.

To be eligible for consideration of ongoing LTD benefits under the Plan, you may be required to undergo a physical examination with your Qualified Medical Provider every 6 (six) months in the first 2 years (24 months) of the LTD benefit period; and annually thereafter.

The cost of any examination that is required for verifying your disability will be at your own expense. Contact your medical plan's member service helpline if you have questions about the cost of the office visits.

Medical examinations conducted for any purpose(s) other than establishing or verifying your disability, for example, for determining your fitness for duty, may not be used to determine your eligibility for disability benefits under the Plan.

Qualified Medical Provider under the Plan is considered to be a licensed Doctor of Medicine ("MD") or Doctor of Osteopathic Medicine ("DO").

Benefit Waiting Period

You must satisfy the Benefit Waiting Period before you become eligible to receive monthly LTD benefits. The Benefit Waiting Period is the time you are away from work due to your disability. The Benefit Waiting Period for:

- Plan I and Plan II is the cumulative total of six months, and
- Plan III is five consecutive months.

If your disability is work-related and you qualify for LTD, LTD benefit payments will begin when you have been off work for the applicable Benefit Waiting Period and your Workers' Compensation benefits have ended.

Benefits for Recurrent Disabilities

If you go back to work and become disabled again within 180 calendar days because of the same condition, your second disability will be counted as part of the first. This means that you will not have to satisfy a new Benefit Waiting Period for benefits to begin. The duration and the amount of your benefit will be based on when you first became disabled.

Social Security Disability Insurance

Your monthly LTD benefit payment will be reduced for Social Security Disability Insurance (SSDI) benefits that you receive. In addition, SSDI benefits may be required for continued LTD benefit eligibility. Therefore, it is important that you contact the Social Security Administration as soon as possible to apply for SSDI.

- The Company has retained the services of Allsup, Inc. (Allsup) as the Company's third-party SSDI advocate. You may be referred to Allsup to represent you in applying for SSDI benefits. If Allsup agrees to represent you, Allsup will handle all of your paperwork at no cost to you. You can call Allsup at 888-339-0743.
- You may elect to retain an attorney to assist you in obtaining SSDI benefits. If so, neither the Company, the third-party LTD administrator, or the third-party SSDI advocate will be responsible for any legal expenses incurred by you for pursuing SSDI benefits.
- You may be required to complete a Social Security authorization form on an annual basis to ensure your Social Security benefit award and claim status information is current.
- If you are receiving SSDI benefits, you are obligated to promptly notify the LTD administrator of any change or additional award since it will impact your LTD benefit.

Return to Work Program

Employees who have been approved for LTD and who are not qualified for SSDI benefits or otherwise waived from participation must fully comply with the Company's Return to Work (RTW) Program. The provisions of the RTW Program require that within 90 days of being put on notice to participate you must:

- consult with a RTW Consultant to identify positions you are capable of performing, and

Complying with the Program

Failure to comply with the RTW Program obligations within the specified time periods will result in the termination of Long-Term Disability benefits and your employment.

- provide your physician with the job function analysis of each position identified, and
- obtain a written assessment from your treating physician of those positions identified by you and a RTW Consultant, and return the physician's written assessment to a RTW Consultant.

Within 45 days after the date of the treating physician's assessment, you must:

- submit transfers and bids to jobs that are consistent with the treating physician's written assessment, and
- schedule and take all qualifying tests required for the classification(s) for which transfers and or bids have been submitted. You must schedule and retake any tests that you failed within 45 days of becoming eligible to retest, and
- accept an offer to any classification for which you are qualified.

If You Are Placed in Another Position

If you are determined disabled for purposes of the LTD Plan, the Company will try to place you in a position in the highest available classification suited to your work capabilities. The classification must have a wage rate which produces a take-home pay, after taxes, which is at least equal to your LTD benefits.

If you are placed in a classification with a lower basic pay rate than your previous classification and you later become unable to perform these new duties solely because of your original disability, the basic monthly rate used in determining your LTD benefit will be the basic monthly rate on the last day you worked in your previous classification or the basic monthly rate of your current classification, whichever is greater.

What the LTD Plan Does Not Cover

LTD benefits will not be paid if your disability results from:

- A condition involving the abuse of alcohol or a controlled substance, as defined by state or federal law. However, benefits will be paid if, as a consequence of your substance abuse, you are suffering from an illness or injury that would otherwise qualify for benefits. For example, cirrhosis of the liver which may result from alcoholism is a covered condition.
- Employment with an employer other than the Company, its domestic subsidiaries or affiliated companies, as may be designated.
- Commission of a crime.
- Attempted suicide.

What Happens to Your Other Benefits

Health Care Benefits

The Company continues your current health care benefits (medical, dental and vision plans). You are responsible for any required premium payments as specified in the applicable healthcare plan and your union agreement. When you become eligible for Medicare (Parts A and B), Medicare will be the first payer of medical claims and the Company's plan(s) will be the second payer of medical claims. The Company will reimburse you for the monthly Medicare Part B base premium amount. It is your responsibility to apply for Medicare coverage; the Company's third-party SSDI advocate, Allsup, can assist you with the application process. You can call Allsup at 888-339-0743.

You should not sign up for Medicare Part D (prescription drugs) outside of the Pacific Gas and Electric Company's enrollment process. See the *Medical Coverage for Participants on Long-Term Disability* section.

Life Insurance

For as long as you qualify for LTD benefits, your Basic and Supplemental Life Insurance coverage then in effect will continue at no cost to you. Your Dependent Life Insurance coverage will remain in effect as long as you remit payment.

Accidental Death and Dismemberment (AD&D) Insurance

For as long as you qualify for LTD benefits, your Basic AD&D Insurance coverage then in effect will continue at no cost to you. Your Voluntary AD&D Insurance coverage will remain in effect as long as you remit payment.

Pacific Gas and Electric Company Retirement Plan and PG&E Corporation Retirement Savings Plan

The period for which you are entitled to receive LTD benefits counts as "credited service" under these benefit plans. LTD benefits paid by the Company are considered covered compensation from which you can make eligible employee contributions to the PG&E Corporation Retirement Savings Plan.

For additional information about your benefits while on LTD, see:

- The *Retirement Benefits* section,
- The PG&E Corporation "Retirement Savings Plan" in the *Retirement Benefits* section and
- The *Health Care Participation* section.

Other Employment and Earnings

While on LTD, you may seek other employment to supplement your LTD benefit. However, if your outside income plus your LTD benefit exceeds 100% of your pre-disability pay, including any adjustment made for other disability income you are entitled to receive, all LTD benefits will be discontinued and your employment will end.

As long as you remain on LTD, each year you must provide the third-party LTD administrator with the following verification of earnings documents:

- A copy of your federal income tax return (Form 1040); and
- If your spouse is employed and a joint return is filed, you must also provide copies of all W-2's to determine the individual earnings; or a completed income statement prepared by a certified public accountant on your earnings. The third-party LTD administrator will provide the appropriate income statement form.
- Additionally, you must provide copies of Schedules C, E, and F, as applicable, and Social Security Form 1099, if you have been awarded Social Security benefits.

You will be notified each year when to submit the verification of earnings documentation. If you do not provide the required information within 90 days of the request, a determination cannot be made on your continued eligibility for benefits, and your LTD benefit and employment will be terminated.

Plan I

LTD benefits will be provided in accordance with the provisions of Plan I for employees who became eligible for LTD prior to January 1, 2000.

Eligibility

You must have been a member of the Group Life Insurance Plan on the date you became disabled to be eligible for LTD benefits. LTD Plan I benefits are provided at no additional cost to eligible employees.

How Much the Plan Pays

LTD Plan I, combined with other benefits, provides you an income equal to 50% of your basic monthly rate of pay.

Your "basic monthly rate of pay" means your regular pay and excludes overtime, premium pay, bonuses, upgrades or other pay on the date you become disabled. The basic monthly rate of pay used to determine LTD benefits is the wage rate of your regular job classification on the date you become disabled.

Benefits for employees who attain part-time or intermittent status on or after January 1, 1991, are prorated based on the ratio of actual straight-time hours worked in the previous calendar year to the full-time hourly equivalent (2,080 hours per calendar year), rounded to the nearest month.

Employees who attained part-time or intermittent status before January 1, 1991, are eligible for LTD Plan I benefits based on the average of their previous six-months' straight-time rate of basic pay.

If You Become Eligible for LTD Benefits at Age 61 or Older

If you become eligible for LTD Plan I benefits at age 61 or older, you may receive LTD Plan I benefits for up to five years, as long as you continue to qualify for LTD Plan I benefits. However, the amount of your benefit will be recalculated as follows:

- If you had 20 years or more of credited service at the time your disability began, your monthly LTD Plan I benefit will be reduced to 40% of your monthly rate of pay at the time of your disability. Your LTD Plan I benefit will be further reduced by 40% of your Social Security retirement benefit and 100% of any payments received from the Pacific Gas and Electric Company Retirement Plan, if applicable.
- If you had less than 20 years of credited service at the time your disability began, your monthly LTD Plan I benefit will be reduced to 30% of your monthly rate of pay at the time of your disability. Your LTD Plan I benefit will be further reduced by 30% of your Social Security retirement benefit and 100% of any payments received from the Pacific Gas and Electric Company Retirement Plan, if applicable.

Coordination of Benefits

Your benefits under the LTD Plan I will be coordinated with (reduced by) other benefits which you may be entitled to receive, including but not limited to:

- The PSEBA Voluntary Wage Benefit Plan (for illnesses or injuries occurring on or before December 31, 2000) or California State Disability Insurance (SDI).
- The Company's Supplemental Benefits for Industrial Injury Plan and any other Workers' Compensation benefits (e.g. Temporary Disability (TD)).
- Any other disability benefits payable by an employer, including those payable under government laws financially supported by an employer.
- 50% of your primary base Social Security disability benefit, including any back-pay awards.
- 100% of the monthly value of any payments received from the Pacific Gas and Electric Company Retirement Plan for your credited service under the retirement plan; including the actuarially equivalent monthly value of any lump sum cash balance benefit paid determined pursuant to Part III of the Retirement Plan.
- Life pensions paid under the Workers' Compensation Act for injuries occurring on or after July 1, 1977 (you are entitled to a life pension if you have received a disability rating of 70% or greater).
- 30% or 40% of your Social Security retirement benefit (depending on your credited service at the time your disability began).

For purposes of calculating your LTD Plan I benefit, it is assumed that you qualify for Social Security disability benefits unless your claim is rejected twice by the Social Security Administration. (You must apply for Social Security disability benefits a second time if your claim is denied the first time.)

Here is an example of how the coordination of benefits provision works:

Sandra has become disabled and has a basic monthly pay of $5,000. The LTD Plan I assures Sandra of a monthly income of $2,500 (50% of $5,000) from all sources. If she is eligible for Social Security disability benefits of $900 a month and $1,000 a month from SDI, her benefit from LTD Plan I will be:

- LTD monthly income $2,500
- Less SDI payments for the month (maximum benefit — 52 weeks) -$1,000
- Less 50% of monthly primary Social Security benefit - $450
- Sandra's monthly benefit from the LTD Plan $1,050

When the California State Disability Insurance payments stop after 52 weeks, Sandra's benefit from the LTD Plan I will increase to $2,050 ($2,500 minus $450 Social Security offset). This LTD Plan I benefit of $2,050, combined with her Social Security benefit of $900, provides her with a total monthly income of $2,950.

While on LTD, adjustments to your monthly LTD benefit will be made any time coordinating benefits cease, begin, or change, regardless of any previous awards or denials you have received. Therefore, you must promptly provide the third-party LTD administrator with a copy of any disability benefit denials, award notifications or changes that you receive from Social Security, the State of California or other disability benefit sources, as it will affect your LTD benefit payments. These adjustments are made on a retroactive basis. For example, if you were denied Social Security disability benefits and later received a retroactive award for these benefits, your LTD benefit would be adjusted retroactively. You must reimburse the Company for any state disability benefits, Social Security disability benefits or other coordinating benefit payments which result in an overpayment of LTD benefits. If you had an initial offset for coordinating benefits which are later denied, the Company will reimburse you for adjustments made which result in an underpayment in LTD benefits.

You are obligated to promptly refund to the Company any overpayment made to you as determined by the third-party LTD administrator for any reason, including, but not limited to, any changes made to any estimated or actual offsets used in determining the LTD Plan I benefit. Failure to comply within the specified time limits will result in your overpayment balance being immediately referred to a collection agency.

Maximum LTD Benefit Period

The maximum duration of your LTD Plan I benefit depends on the length of your credited service as defined under the Pacific Gas and Electric Company Retirement Plan.

Your Length of Credited Service —As of the date of disability	LTD Benefits are Payable Up To
Less than 5 years	5 years
At least 5 years but less than 15 years	A period of time equal to your length of credited service (unless you reach normal retirement age under the Pacific Gas and Electric Company Retirement Plan)
15 years or more	Normal retirement age as defined under the Pacific Gas and Electric Company Retirement Plan

Employees who become eligible for LTD Plan I benefits at age 61 or older should refer to "If You Become Eligible for LTD Benefits at Age 61 or Older" under "Plan I" on page 298 for information regarding their maximum LTD Plan I benefit period.

When LTD Benefits End

LTD Plan I benefits will end on the earliest of the following events:

- You recover from your disability and are medically released to return to work.
- You refuse a position at the Company which has duties equal to your reduced work capabilities.
- You start earning income from some other form of work that is equal to more than 50% of your monthly salary on the last day you worked prior to becoming disabled.
- You do not comply with the provisions of the verification of earnings requirement.
- You reach normal retirement age under the Pacific Gas and Electric Company Retirement Plan (unless LTD eligibility begins at age 61 or older; see "If You Become Eligible for LTD Benefits at Age 61 or Older" under "Plan I" on page 298.
- You are no longer eligible for LTD Plan I benefits because you reach the maximum benefit period (see "Maximum LTD Plan Benefit Period" under "Plan I" on page 298.
- You do not follow your physician's recommended treatment program.
- You do not comply with the provisions of the medical certification requirement.
- You do not comply with the provisions of the Company's Return to Work Program.
- You are terminated or leave the Company.
- You return to work at the Company as a hiring hall employee.
- Your death.

Plan II

LTD benefits will be provided in accordance with the provisions of Plan II for employees who became eligible for LTD on or after January 1, 2000 and whose onset of disability was prior to:

- June 1, 2003 (if IBEW Clerical, ESC or SEIU), or
- October 1, 2003 (if IBEW Physical).

Eligibility

You must have been a member of the Group Life Insurance Plan on the date you became disabled to be eligible for LTD benefits. LTD Plan II benefits are provided at no additional cost to eligible employees.

How Much the Plan Pays

LTD Plan II, combined with other benefits, provides you an income equal to 66⅔% of your basic monthly rate of pay.

Your "basic monthly rate of pay" means your regular pay on the date you become disabled and excludes overtime, premium pay, bonuses, upgrades or other pay. The basic monthly rate of pay used to determine LTD benefits is the applicable wage rate of your regular job classification on the date you become disabled.

Benefits for employees who attain part-time or intermittent status on or after January 1, 1991, are prorated based on the ratio of actual straight-time hours worked in the previous calendar year to the full-time hourly equivalent (2,080 hours per calendar year), rounded to the nearest month.

Employees who attained part-time or intermittent status before January 1, 1991, are eligible for LTD Plan II benefits based on the average of their previous six-months' straight-time rate of basic pay.

If You Become Eligible for LTD Benefits at Age 61 or Older

If you become eligible for LTD Plan II benefits at age 61 or older, you may receive LTD Plan II benefits for up to five years, as long as you continue to qualify for LTD Plan II benefits. However, the amount of your benefit will be reduced by 100% of your Social Security retirement benefit and 100% of any payments received from the Pacific Gas and Electric Company Retirement Plan, if applicable.

Coordination of Benefits

Your benefits under the LTD Plan II will be coordinated with (reduced by) other benefits which you may be entitled to receive, including but not limited to:

- The PSEBA Voluntary Wage Benefit (for illnesses or injuries occurring on or before December 31, 2000) or California State Disability Insurance (SDI).
- The Company's Supplemental Benefits for Industrial Injury Plan and any other Workers' Compensation benefits (e.g. Temporary Disability (TD)).
- Any other disability benefits payable by an employer, including those payable under government laws financially supported by an employer.
- 100% of your primary base Social Security disability benefit, including any back-pay awards.
- 100% of the monthly value of any payments received from the Pacific Gas and Electric Company Retirement Plan for your credited service under the retirement plan; including the actuarially equivalent monthly value of any lump sum cash balance benefit paid determined pursuant to Part III of the Retirement Plan.
- Life pensions paid under the Workers' Compensation Act for injuries occurring on or after July 1, 1977 (you are entitled to a life pension if you have received a disability rating of 70% or greater).
- 100% of your Social Security retirement benefit.

For purposes of calculating your LTD Plan II benefit, it is assumed that you qualify for Social Security disability benefits unless your claim is rejected twice by the Social Security Administration. (You must apply for Social Security disability benefits a second time if your claim is denied the first time.)

Here is an example of how the coordination of benefits provision works:

Sandra has become disabled and has a basic monthly pay of $7,500. The LTD Plan II assures Sandra of a monthly income of $5,000 — 66⅔% of $7,500 — from all sources. If she is eligible for Social Security disability benefits of $1,000 a month and $3,600 a month from SDI, her LTD benefit from the LTD Plan II will be:

▪ LTD monthly income	$5,000
▪ Less SDI payments for the month (maximum benefit — 52 weeks)	-$3,600
▪ Less 100% of monthly primary Social Security benefit	- $1,000
▪ Sandra's monthly benefit from the LTD Plan	$400

When the SDI payments stop after 52 weeks, Sandra's benefit from the Company's LTD Plan II will increase to $4,000 ($5,000 minus $1,000 for Social Security offset). This LTD benefit of $4,000, combined with her Social Security benefit of $1,000, provides her with a total monthly income of $5,000.

While on LTD, adjustments to your monthly LTD benefit will be made any time coordinating benefits cease, begin, or change, regardless of any previous awards or denials you have received. Therefore, you must promptly provide the third-party LTD administrator with a copy of any disability benefit denials, award notifications or changes that you receive from Social Security, the State of California or other disability benefit sources, as it will affect your LTD benefit payments. These adjustments are made on a retroactive basis. For example, if you were denied Social Security disability benefits and later received a retroactive award for these benefits, your LTD benefit would be adjusted retroactively. You must reimburse the Company for any state disability benefits, Social Security disability benefits or other coordinating benefit payments which result in an overpayment of LTD benefits. If you

had an initial offset for coordinating benefits which are later denied, the Company will reimburse you for adjustments made which result in an underpayment in LTD benefits.

You are obligated to promptly refund to the Company any overpayment made to you as determined by the third-party LTD administrator for any reason, including, but not limited to, any changes made to any estimated or actual offsets used in determining the LTD Plan II benefit. Failure to comply within the specified time limits will result in your overpayment balance being immediately referred to a collection agency.

Maximum LTD Benefit Period

The maximum duration of your LTD Plan II benefit will be to age 65, unless your disability is a mental/nervous disability and is subject to a two-year limit. You may not continue to receive LTD Plan II benefits beyond age 65 unless you became eligible for LTD Plan II benefits at age 61 or older. In such a case, you would be entitled to a maximum LTD Plan II benefit period of five years.

Two-Year Limit on Mental/Nervous Disabilities

In general, LTD Plan II benefits for mental/nervous disabilities are subject to a two-year maximum benefit period. The two-year limit will not apply if your disability is due to a severe mental disorder including schizophrenia, dementia, organic brain syndromes, delirium, amnesia syndromes or organic delusional or hallucinogenic syndromes. If you are awarded Social Security disability benefits prior to the end of the two-year limit, your LTD Plan II benefit may continue up to your normal retirement date as long as you continue to qualify for LTD Plan II benefits. If you are hospitalized or institutionalized on the date your two-year limit expires, your LTD Plan II benefit will continue for the duration of the stay, but not to exceed your normal retirement date.

When LTD Benefits End

LTD Plan II benefits will end on the earliest of the following events:

- You recover from your disability and are medically released to return to work.
- You refuse a position at the Company which has duties equal to your reduced work capabilities.
- You start earning income from some other form of work that is equal to more than 33⅓% of your monthly salary on the last day you worked prior to becoming disabled.
- You do not comply with the provisions of the verification of earnings requirement.
- You reach normal retirement age under the Pacific Gas and Electric Company Retirement Plan (unless LTD eligibility begins at age 61 or older; see “If You Become Eligible for LTD Benefits at Age 61 or Older” under “Plan II” on page 301.
- You reach the two-year limit to which some mental/nervous disabilities are subject.
- You do not follow your physician’s recommended treatment program.
- You do not comply with the provisions of the medical certification requirement.
- You do not comply with the provisions of the Company’s Return to Work Program.
- You are terminated or leave the Company.
- You return to work at the Company as a hiring hall employee.
- Your death.

Plan III

LTD benefits will be provided in accordance with the provisions of Plan III for employees whose onset of disability is on or after:

- June 1, 2003 (if IBEW Clerical, ESC or SEIU), or
- October 1, 2003 (if IBEW Physical).

Eligibility

LTD Plan III benefits are provided at no additional cost to eligible employees.

How Much the Plan Pays

LTD Plan III, combined with other benefits, provides you an income equal to 66⅔% of your basic monthly rate of pay.

Your "basic monthly rate of pay" means your regular pay excluding overtime, premium pay, bonuses, upgrades or other pay, on the date you become disabled. The basic monthly rate of pay used to determine LTD benefits is the applicable wage rate of your regular job classification on the date you become disabled.

Benefits for employees who attain part-time or intermittent status on or after January 1, 1991, are prorated based on the ratio of actual straight-time hours worked in the previous calendar year to the full-time hourly equivalent (2,080 hours per calendar year), rounded to the nearest month.

Employees who attained part-time or intermittent status before January 1, 1991, are eligible for LTD Plan III benefits based on the average of their previous six-months' straight-time rate of basic pay.

Coordination of Benefits

Your benefits under the LTD Plan III will be coordinated with (reduced by) other benefits which you may be entitled to receive, including but not limited to:

- California State Disability Insurance (SDI).
- The Company's Supplemental Benefits for Industrial Injury Plan and any other Workers' Compensation benefits (e.g. Temporary Disability (TD)).
- Any other disability benefits payable by an employer, including those payable under government laws financially supported by an employer.
- 100% of your primary and family base Social Security disability benefit, including any back-pay awards.
- 100% of the monthly value of any payments received from the Pacific Gas and Electric Company Retirement Plan for your credited service under the retirement plan; including the actuarially equivalent monthly value of any lump sum cash balance benefit paid determined pursuant to Part III of the Retirement Plan.
- Life pensions paid under the Workers' Compensation Act for injuries occurring on or after July 1, 1977 (you are entitled to a life pension if you have received a disability rating of 70% or greater).
- 100% of your Social Security retirement benefit.
- Any amount payable under the Railroad Retirement Act.

For purposes of calculating your LTD Plan III benefit, no Social Security offset will be assumed until Social Security disability benefits are actually granted. You are responsible for immediately notifying the third-party LTD administrator of such an award, and for repaying the Company the full amount of the LTD overpayment at the time you receive your Social Security award.

Here is an example of how the coordination of benefits provision works:

Sandra has become disabled and has a basic monthly pay of $8,400. The LTD Plan III assures Sandra of a monthly income of $5,600 — 66⅔% of $8,400 — from all sources. If she has been awarded primary and family Social Security disability benefits of $1,800 a month ($1,200 primary plus $600 family) and $3,600 a month from SDI, her LTD benefit from the LTD Plan III will be:

LTD monthly income	$5,600
Less SDI payments for the month (maximum benefit — 52 weeks)	- $3,600
Less 100% of monthly primary and family Social Security benefit	- $1, 800
Sandra's monthly benefit from the LTD Plan	$200

When the SDI payments stop after 52 weeks, Sandra's benefit from the Company's LTD Plan III will increase to $3,800 ($5,600 minus $1,800 for primary and family Social Security offset). This LTD benefit of $3,800, combined with her Social Security benefit of $1,800, provides her with a total monthly income of $5,600.

While on LTD, adjustments to your monthly LTD benefit will be made any time coordinating benefits cease, begin or change, regardless of any previous awards or denials you have received. Therefore, you must promptly provide the third-party LTD administrator with a copy of any disability benefit denials, award notifications or changes that you receive from Social Security, the State of California or other disability benefit sources, as it will affect your LTD benefit payments. These adjustments are made on a retroactive basis. For example, if you were denied Social Security disability benefits and later received a retroactive award for these benefits, your LTD benefit would be adjusted retroactively. You must reimburse the Company for any state disability benefits, Social Security disability benefits or other coordinating benefit payments which result in an overpayment of LTD benefits. If you had an initial offset for coordinating benefits which are later denied, the Company will reimburse you for adjustments made which result in an underpayment in LTD benefits.

You are obligated to promptly refund to the Company any overpayment made to you as determined by the third-party LTD administrator for any reason, including, but not limited to, any changes made to any estimated or actual offsets used in determining the LTD Plan III benefit. If an overpayment in LTD Plan III benefits occurs due to a Social Security disability benefit award, you have 30 days to repay the overpaid amount. If you do not repay the Company within 30 days of receiving the SSDI benefit payment, your LTD benefit will stop until the full overpayment is recouped. Failure to comply within the specified time limits will result in your overpayment balance being immediately referred to a collection agency.

Social Security Disability Insurance

You will be required to complete a Social Security authorization form on an annual basis to ensure your Social Security benefit award and claim status information is current.

Maximum LTD Benefit Period

Under Plan III, the maximum duration of your LTD Plan III benefit is as follows:

- If you are not receiving a Social Security disability benefit at the end of two years of LTD eligibility, your LTD Plan III benefit will stop and your employment will be terminated at that time.
- If you are receiving a Social Security disability benefit at the end of two years of LTD eligibility, the maximum duration of your LTD Plan III benefit will be to the earlier of age 65, or the termination of Social Security disability benefits.
- If you are age 63 or older when you become eligible for a LTD Plan III benefit, the maximum duration of your LTD Plan III benefit will be two years.

Extension of LTD Plan III Benefits Beyond Two Years

If the Company's third-party Social Security Disability Insurance (SSDI) advocate is representing your interest in applying for Social Security disability benefits and if you have not received a final Social Security disability ruling within 24 months of the initial receipt of LTD benefits through no fault of your own, as determined by the advocate, you may receive a monthly extension of up to an additional 36 months of LTD benefits or until you reach age 65, whichever happens first. You must fully cooperate with the advocate and must defer the processing of your Social Security application to the discretion of the advocate. If the advocate has closed your claim for Social Security representation for any reason during the extension period, your LTD benefits and employment will be terminated. In addition, if Social Security disability benefits have not been awarded at the end of the extension, your LTD benefits and employment will be terminated.

If you have been terminated from LTD and employment with Pacific Gas and Electric Company, and are later awarded Social Security disability benefits retroactive to the period in which you were receiving LTD benefits, your LTD benefits and employment will be reinstated retroactive to the original date that LTD benefits ended.

When LTD Benefits End

LTD Plan III benefits will end on the earliest of the following events:

- You recover from your disability and are medically released to return to work.
- You refuse a position at the Company which has duties equal to your reduced work capabilities.
- You start earning income from some other form of work that is equal to more than 33⅓% of your monthly salary on the last day you worked prior to becoming disabled.
- You do not comply with the provisions of the verification of earnings requirement.
- You do not comply with providing the annual Social Security authorization form.
- You reach normal retirement age under the Pacific Gas and Electric Company Retirement Plan.
- You reach the two-year limit and do not have a Social Security disability benefit.
- You reach the two-year limit because you were age 63 or older when you became eligible for LTD Plan III benefits.
- Your claim for Social Security representation is closed by the advocate for any reason during the monthly extension period.
- You have not been awarded Social Security disability benefits at the end of the monthly extension.
- You do not follow your physician's recommended treatment program.
- You do not comply with the provisions of the medical certification requirement.
- You do not comply with the provisions of the Company's Return to Work Program.
- You are terminated or leave the Company.
- You return to work at the Company as a hiring hall employee.
- Your death.

Claims and Appeals — Plans I, II and III

Claims

If you submit a written application for LTD benefits, you will receive a ruling from the third-party administrator within 45 days following the administrator's receipt of your claim and evidence of medical disability that precludes you from performing the normal duties of your job.

If you submit a claim that is incomplete, or does not include the required medical evidence, you will be notified that an extension is needed and the additional information necessary to make a decision on your claim. The third-party LTD 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 LTD administrator to make a decision. The third-party LTD administrator will make a decision on the claim within 30 days after receipt of this information or within 30 days after the expiration of your 45-day deadline to provide the information, whichever is earlier.

Once a full and complete claim has been submitted, the third-party LTD administrator may, due to matters beyond the Plan's control, extend its 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 LTD 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 LTD administrator expects to render its decision.

If you have been denied a benefit, in whole or in part, by the third-party LTD administrator, your written denial from the third-party LTD 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 the 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.

In addition, if your denial is based on the third-party LTD 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.

Appeals

If you are not satisfied with the third-party LTD administrator's decision, you or your authorized representative may submit a written appeal to the Employee Benefit Appeals 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 LTD administrator.

Send your appeal to:

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

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

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 assist 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 after 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;
- a reference to the specific Plan provision(s) on which the denial is based;
- notification that you may 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 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.

In addition, 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, protocol or other similar criterion, free of charge.

If your denial is based on a disagreement with respect to medical opinions as to whether you are or are not disabled within the meaning of the Long-Term Disability Plan, your case will be submitted to an impartial physician for determination. The Company will supply you with a list of more than two qualified physicians in the field. You select the physician you want to perform the examination. The Company pays the costs for the examination and report.

Instead of electing to use the appeals steps through EBAC, a Bargaining Representative 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 Long-Term Disability Plan benefits.

Workers' Compensation

Pacific Gas and Electric Company, and PG&E Corporation and its covered affiliates (referred to collectively as "Company" in this section) are self-insured under state law, and in addition, Pacific Gas and Electric Company maintains self-insurance under the federal Longshore and Harbor Workers' Compensation Act, to provide Workers' Compensation benefits for employee injury or illness which arises out of and occurs in the course of work. The Workers' Compensation program provides you with partial income replacement in the form of disability benefits and medical treatment. In the event of a work-related death, the program provides your dependents with death and burial benefits. The Workers' Compensation program is administered by the Pacific Gas and Electric Company Workers' Compensation Department.

You should note that the Company is not responsible for Workers' Compensation benefits for any injury or illness that results from your voluntary participation in any off-duty recreational, social or athletic activity that is not part of your work-related duties.

Contractors and agency workers are not entitled to the Company's Worker's Compensation benefits.

Procedures in the Event of an Industrial Injury or Illness

The Company's extensive safety program helps you to avoid injury. However, in the event of an industrial injury or illness, you will be provided with all medical care that is reasonably required to cure or relieve the effects of the injury or illness. Every reasonable effort will be made to minimize the extent and duration of your injury or illness and to continue the appropriate medical care. In addition, you will be provided ongoing contact with the Company's Workers' Compensation Representatives, timely referrals to medical specialists and the Company's Return to Work program, as reasonably necessary, and additional other benefits which exceed the requirements of state law.

Work-Related Injury or Illness

In an emergency, go to the nearest emergency medical facility and, as soon as possible, contact the Safety and Workers' Compensation Helpline (Helpline) at 415-973-8700 (outside) or Company number 8-223-8700, and select Option 2.

Every industrial injury or illness must be reported to your supervisor as soon as possible. After your supervisor has been notified, you should call the 24/7 Nurse Report Line at 888-449-7787. An intake representative will confirm the basic contact information and incident details, and then transfer you to a nurse or doctor who will assess the situation and you will either receive self-care recommendations or be referred to a doctor within the Company's medical provider network. The incident will be reported entirely over the phone and you and your supervisor will receive an email that documents the call, and will serve as the official incident report. No personal medical information will be shared with your supervisor or PG&E during this process. The Company will provide you a Workers' Compensation claim form if applicable to your situation.

Predesignation of Personal Physician

If a Personal Physician Treatment Request Form (Form #62-4068) is on file prior to the industrial injury or illness, you may be treated by your own physician instead of a doctor in the Medical Provider Network (MPN).

- Due to changes in workers' compensation law regarding pre-designation of a personal physician, the current form you should submit is the Notice of Predesignation of Personal Physician (Optional DWC Form 9783 March 1, 2007).

- The Company will honor old Request forms on file, unless your previous designation was a chiropractor or acupuncturist. In such cases, you should complete a new Request form pre-designating a regular physician who is not a chiropractor or acupuncturist.
- If you wish to submit a new Request form, or make changes to an existing form, a new form should be completed to document those changes.
- Hiring Hall employees are not entitled to pre-designate a personal physician.

Definition of Personal Physician

If you have a Personal Physician Treatment Request Form on file prior to the date of injury or illness, you have the right to be treated by that physician from the date of injury or illness.

A personal physician must meet all of the following conditions:

- The physician is your regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.
- The physician is your primary care physician and has previously directed your medical treatment, and retains your medical records, including your medical history. "Personal physician" includes a medical group, if the medical group is a single corporation or partnership composed of licensed doctors of medicine or osteopathy that operates an integrated multi-specialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries.

Medical Provider Network (Panel of Physicians)

The Company has partnered with Kaiser on the Job (KOJ) and Anthem Blue Cross, a national managed-care company, to develop the PG&E/Anthem Blue Cross Medical Provider Network (MPN).

For non-emergency situations, you may use either the Network link or contact your Workers' Compensation Representative (WCR) for a referral to a MPN provider for initial treatment. If you are temporarily working outside the MPN service area you may get treatment from a doctor of your choice. The Network link is a partial listing of the MPN, developed to assist in the initial referral to an appropriate provider.

If you would like to review, receive, or access the complete MPN provider directory, you can:

- visit the MPN website at www.pge.com/mpn, or
- call Kaiser on the Job at 888-KOJ-WORK or Anthem Blue Cross at 866-700-2168.

If you have difficulty getting an appointment or need any assistance in locating a MPN provider you may contact your WCR or the Safety and Workers' Compensation Helpline at 415-973-8700 (outside) or Company number 8-223-8700, and select Option 2.

Supplemental Benefits for Industrial Injury Plan

The Supplemental Benefits for Industrial Injury Plan is designed to provide employees of Pacific Gas and Electric Company with supplemental income benefits — above your Workers' Compensation disability income — if you sustain an injury or illness on the job and are entitled to temporary disability benefits. ("Company," in this Supplemental Benefits for Industrial Injury Plan section, means Pacific Gas and Electric Company only.)

You are not eligible for benefits from the Supplemental Benefits for Industrial Injury Plan if you are a contract or agency worker, a hiring hall employee, or an employee of PG&E Corporation, PG&E Corporation Support Services, Inc., or PG&E Corporation Support Services II, Inc.

When Benefits Begin

Benefits can begin on the first lost workday after an injury or illness occurs. Plan benefits can continue as long as you are entitled to workers' compensation temporary disability benefits, or within the limits prescribed by law.

Benefits from the Supplemental Benefits for Industrial Injury Plan are not automatic. To apply for benefits, you must complete and sign the "Request and Application for Permanent Disability Advances Paid as Supplemental Benefits" form.

If your disability turns out to be permanent, all or some of the Supplemental Benefits paid during your absence from work may be deducted from any permanent disability benefits you are entitled to receive under Workers' Compensation. For injuries or illnesses occurring on or after January 1, 1991, the sum of Supplemental Benefits, net of taxes, paid during the first 182 days of absence will constitute a credit against permanent disability benefits.

How Much the Plan Pays

Combined with other disability benefits, the Plan assures you of an income equal to:

- 75% of your basic weekly wage rate for injuries/illnesses occurring on or after January 1, 2000 (no change at the 183rd day);
- 85% of your basic weekly wage rate for the first 182 days you are absent from work, and 66⅔% of your basic weekly wage rate starting on the 183rd day you are absent from work for injuries/illnesses occurring on or after January 1, 1991, through December 31, 1999; or
- 85% of your basic weekly wage rate for the first 182 days you are absent from work, and 75% of your basic weekly wage rate starting on the 183rd day you are absent from work for injuries/illnesses occurring on or after January 1, 1983, through December 31, 1990.

Your "basic weekly wage rate" means your regular pay and excludes overtime, premium pay, bonuses or other pay. In calculating your benefit amount, the Supplemental Benefits for Industrial Injury Plan will deduct any payments you are entitled to under the Workers' Compensation and Insurance Chapters of the California Labor Code or the State Disability Insurance plan.

When Benefits End

Your benefits from the Supplemental Benefits for Industrial Injury Plan will end on the earliest of the following events:

- You are released to return to your usual and customary job.
- You refuse an offer of modified or transitional duty work at the Company.
- You refuse work with the Company under a rehabilitation plan.
- You accept a job outside of the Company.
- You are medically rehabilitated.
- Your temporary disability benefits end, due to the two-year time limit, or for any other reason.
- Your employment status is terminated for any reason.
- You transfer to the Long-Term Disability payroll.
- You retire.
- Your death.

Returning to Work

If you are disabled, the Company will make every effort to help you return to work as soon as you are able. Depending on your medical condition and the availability of appropriate jobs, the Company may ask you to perform transitional duties temporarily for a duration that, in most cases, will not exceed six months, until you are released to full duties and/or your medical condition reaches a "permanent and stationary" status. Your condition will be considered "permanent and stationary" when your physician reports that your medical condition has reached maximum medical improvement or has been stabilized for a reasonable period of time. While on transitional duty, you will be paid at the rate of pay for your regular position. Your treating physician must approve the transitional duty and will help the Company decide when you can resume your regular duties.

Claims and Appeals

Claims

Benefits from the Supplemental Benefits for Industrial Injury Plan are not automatic. To apply for benefits, you must complete and sign the "Request and Application for Permanent Disability Advances Paid as Supplemental Benefits" form that you will receive from the Workers' Compensation Department upon becoming disabled due to an industrial injury.

If you submit a claim that is incomplete, you will be notified that an extension is needed and the additional information necessary to make a decision on your claim. Workers' Compensation (Claims Administrator) will provide this notice not more than 45 days after receipt of your claim. You will have 45 days to provide the other information necessary for the Claims Administrator to make a decision. The Claims administrator will make a decision on the claim within 30 days after receipt of this information or within 30 days after the expiration of your 45-day deadline to provide the information, whichever is earlier.

Once a full and complete claim has been submitted, the Claims Administrator may, due to matters beyond the Plan's control, extend its review of your claim for up to two additional 30-day periods if additional information is still needed. You must be notified before the end of the initial 45-day period, if an initial extension of up to 30 days is required and told why the extension is necessary and when the Claim 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 Claim Administrator expects to render its decision.

If you believe you have been denied a benefit to which you may be entitled, you may appeal the claim to the Workers' Compensation Department within 45 days after you receive the denial by writing to the following address:

Pacific Gas and Electric Company
Workers' Compensation Department, B23H
Claim Administrator Appeals
Attention: Sr. Manager, Workers' Compensation Section
P.O. Box 7779
San Francisco, CA 94120-7779

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 Workers' Compensation Department to administer the Plan fairly, consistently, and in accordance with the provisions of the Plan.

If the Claim Administrator denies your claim, you will receive a written response which will include:

- the specific reason(s) for the denial of the claim;
- a reference to the Plan provision(s) 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; and
- a description of the Plan's review procedures and the time limits applicable to such procedures.

Life and Accident Insurance Plans

To help you provide financial security for your loved ones in the event of your death or serious injury, the Company offers:

- $10,000 of Company-paid basic term life insurance coverage, through the Group Life Insurance Plan;
- The option to purchase additional, supplemental term life insurance coverage for you, your spouse or registered domestic partner and your children or the children of your registered domestic partner, through the Group Life Insurance Plan;
- $10,000 or $250,000 of Company-paid basic accidental death and dismemberment (AD&D) insurance, depending on your job level;
- The option to purchase additional, voluntary AD&D insurance coverage for you, your spouse or registered domestic partner, and your children or the children of your registered domestic partner; and
- Business Travel Accident insurance coverage.

Additionally, you may be eligible for continued life insurance coverage when you retire.

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation. The plans and benefits described in this section are also applicable to employees of designated subsidiaries and affiliates, but only to the extent that such entities are participating employers with respect to the described plans or programs and such employees meet the eligibility requirements of the plans or programs.

Cost of Coverage

The Company pays the full cost for $10,000 of Group Life Insurance Plan coverage, as well as for $10,000 of Accidental Death and Dismemberment (AD&D) Insurance coverage — this is your basic coverage. If you want to enroll for additional, supplemental Life and/or Voluntary AD&D Insurance coverage, you pay for that coverage with convenient after-tax salary deductions.

In addition to the cost for your basic life and basic AD&D insurance coverage, the Company currently pays the full cost of premiums for the following:

- Group Life Insurance at retirement, and
- Business Travel Insurance.

Imputed Income from Your Life Insurance Coverage

The value of your group life insurance over $50,000 (as determined by IRS tables) is includible as additional income on your W-2 as imputed income. This "imputed income" is based on your age at rates set by the IRS. Imputed income is calculated each month and is automatically included in the wages shown on your pay statement as well as your annual W-2 form.

Claims Administrators and Insurers

- Metropolitan Life Insurance Company (MetLife) is both the Claims Administrator and the insurer of the life insurance and accidental death and dismemberment benefits.
- Life Insurance Company of North America (LINA) is both the Claims Administrator and the insurer of the business travel accident benefit.

Additional Information

In addition to the information in this section, there is also important information about your benefits in other parts of this Handbook. Be sure to review the *About this Handbook* section, the *Benefits at a Glance* section, the *What If...* section, and the *Rules, Regulations & Administrative Information* section.

Plan Documents and Administration

The plan document for The Pacific Gas and Electric Company Group Life Insurance Plans, the terms of this Summary of Benefits Handbook which pertain to the Group Life Insurance Plans, the documents which are Summaries of Material Modifications to the Group Life Insurance Plans, and the applicable life insurance policies govern the operation of the Group Life Insurance Plans and comprise the Plan document. If a conflict exists between these plan documents and any other communications or documents, the plan documents shall govern the operation of the Group Life Insurance Plans.

The Employee Benefit Committee of PG&E Corporation is the Plan Administrator of the Group Life Insurance Plans and has the discretionary authority to interpret and construe the terms of the plan documents, to resolve any conflicts or discrepancies between documents and to establish rules which are necessary or desirable for the administration of the Plans. Notwithstanding the foregoing, the insurer has the authority to construe and interpret the terms of the life and accident insurance policies, the certificate of insurance or other similar documents which describe the terms and conditions of the life and accident insurance policies. Nothing in the plan documents or any other communication or document is intended to provide any individual with a substantive right to life and accident insurance benefits that is not provided for in the life and accident insurance policies.

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Group Life Insurance

The Company automatically provides you with $10,000 in Basic Life Insurance coverage. You may also purchase supplemental life insurance coverage for you, your spouse or registered domestic partner, and/or your children and/or the children of your registered domestic partner, which you pay for through after-tax salary deductions.

The amount of life insurance you need may depend on several factors, including your age, family status and other financial resources.

Employee Supplemental Life Insurance

The Group Life Insurance Plan offers you multiple levels of supplemental life insurance coverage from which to choose, up to a maximum of $1,000,000, as follows:

- Standard Life ($50,000)
- Life 1 (1.5 times your base annual pay)
- Life 2 (2 times your base annual pay)
- Life 3 (3 times your base annual pay)
- Life 4 (4 times your base annual pay)
- Life 5 (5 times your base annual pay)
- Life 6 (6 times your base annual pay)

The supplemental coverage amounts are in addition to the $10,000 of Company-provided Basic coverage.

Your "base annual pay" means your annualized base rate of pay and does not include overtime or any other special compensation. Your calculated supplemental insurance amount will be rounded to the next higher $1,000.

Effect of an Increase or Decrease in Rate of Pay

The amount of your insurance will automatically go up or down whenever you receive a raise that is other than temporary. The new amount will go into effect on the first day of the calendar month following the date of change, unless you are absent from work on that day because of illness or injury. In that case, your new coverage amount will become effective when you return to work.

Coverage for Intermittent Employees

If you are a regular intermittent employee who works on a non-scheduled, part-time basis and you meet all of the Group Life Insurance Plan's eligibility requirements, you will receive life insurance coverage in the amount of $10,000.

If you transfer from a full-time to an intermittent job, you may retain the amount of coverage you had immediately prior to your transfer to intermittent status, or you may decrease your coverage to $10,000.

Dependent Life Insurance

You may elect life insurance for your spouse or registered domestic partner and/or your children and/or the children of your registered domestic partner.

Spouse/Registered Domestic Partner Life Insurance

When you elect Supplemental Life for yourself, you may elect Supplemental Life Insurance coverage for your spouse or registered domestic partner. If elected within 90 days of eligibility, coverage of up to $25,000 is automatically approved by Metropolitan Life Insurance Company — no evidence of good health is required. The coverage amount for your spouse's or registered domestic partner's benefit cannot be more than 50% of your total Basic and Supplemental Life Insurance coverage amounts. If you elect spouse/registered domestic partner coverage, your contributions are paid with after-tax dollars from your pay.

Coverage	Benefit Amount
Spouse or Registered Domestic Partner	▪ $10,000 ▪ $25,000 ▪ $50,000 ▪ $75,000 ▪ $100,000

Dependent Child Life Insurance

You may elect dependent child life insurance coverage for your children and/and or the children of your registered domestic partner. You do not need to elect Supplemental Life for yourself in order to elect coverage for your child(ren) and you may enroll or increase coverage at any time, without evidence of good health. If you elect dependent child life insurance coverage, your contributions are paid with after-tax dollars from your pay.

Coverage	Benefit Amount
Child(ren)	You may purchase: ▪ $5, 000, $10,000 or $25,000 for each dependent child from the age of 14 days to age 26. ▪ $1,000 for any child who is younger than 14 days old.

You are automatically the beneficiary of any life insurance benefits purchased for your dependent(s). Benefits are not payable if your spouse, registered domestic partner or dependent child commits suicide within two years of election of benefits; if applicable, any premiums that you paid will be refunded.

Eligibility, Enrollment and Cost

You are eligible to participate in the life insurance plan the first of the month after you have completed six months of employment and attained Regular status, if you are a full-time or part-time union -represented employee of the Company. You are not eligible for this life insurance plan if you are a contractor, agency worker, hiring hall employee, or retired employee. Intermittent employees (except as noted) and other temporary employees who are not expected to become regular employees are also not eligible for coverage.

Enrollment

Your life insurance coverage described in this section will go into effect the first day of the month following receipt of your elections, provided you complete the enrollment process within 90 days of the date on which you first satisfy the eligibility requirements. For example, if you were hired on February 1 as a union-represented employee, you satisfy the eligibility requirements on August 1 and you complete the enrollment process on August 15, you would be eligible for life insurance, above the Company-provided Basic Life, on September 1.

Metropolitan Life Insurance Company will send an enrollment welcome package to your home for response within 90 days of your hire or other eligibility date. You may also enroll at https://mybenefits.metlife.com/PG&E or by calling Metropolitan Life Insurance Company directly at 888-878-8490. If you do not complete the enrollment process when initially eligible, you will be assigned Basic Life Insurance coverage in the amount of $10,000. You may increase your level of coverage by enrolling for supplemental life insurance coverage at any time during the year. After your initial eligibility period, you will only be allowed to elect up to two times annual pay without providing evidence of good health.

You must be actively at work on or after the effective date of your enrollment for coverage changes to take effect (e.g., if you are on sick leave or a leave of absence without pay, any changes to your life insurance coverage will not take effect until you return to work).

Actively at Work

"Actively at work" means you are performing all of the usual and customary duties that pertain to your work at the place where it is normally done, or where it is required to be done by your employer.

Cost of Coverage

The monthly cost for supplemental coverage depends on your age. You should refer to your personalized information for employee, spouse or registered domestic partner, and/or child(ren) coverage when you log in to the MetLife website.

How Your Benefit Is Paid

Life insurance benefits are typically paid to your beneficiary in a single payment. Installment payments may be available. For information on installment payments, call Metropolitan Life Insurance Company at 888-878-8490.

Your Beneficiary

Your beneficiary is the person or persons to whom a benefit will be paid in the event of your death. Your beneficiary can be anyone you choose, and you can name more than one beneficiary. In addition, you may name a trust, charity or estate. For spouse, registered domestic partner, and child life insurance benefits, you are the beneficiary.

More than One Beneficiary

If you designate more than one person as your beneficiary, each will share in the benefits equally, unless you have designated specific percentages for each beneficiary.

If a benefit is payable to a minor, the benefits may be paid to a Court Appointed Guardian of Person and Property of the Minor's Estate, or deposited into a MetLife interest-bearing account that becomes accessible to the minor when the minor reaches age 18. Before naming a minor as your beneficiary, we suggest that you consult with your legal advisor.

Designating or Changing Your Beneficiary

To establish, change or review your beneficiary designations, you can visit Metropolitan Life MyBenefits website at https://mybenefits.metlife.com/PG&E.

If you do not have access to the internet, you can contact Metropolitan Life Insurance Company by phone at its toll-free number, and request a paper beneficiary form to be sent to you for completion.

It is important that you always keep your beneficiary designations up to date. This is your responsibility. You may change your beneficiary designations at any time. Beneficiary designations and changes are effective on the date they are accepted by Metropolitan Life's MyBenefits Beneficiary Management website. Paper designations and changes are effective on the date you sign the notice. Any beneficiary designation or change will not affect any payment Metropolitan Life Insurance Company makes or actions it takes before the notice of designation or change is submitted and processed.

Death of a Beneficiary

A person's rights as a beneficiary end if that person dies:

- before your death occurs; or
- at the same time your death occurs; or
- within 24 hours of your death.

The share for that person will be divided among the surviving persons you have named as beneficiary, unless you have chosen otherwise.

No Beneficiary at Your Death

If no beneficiary should survive you, your benefit will be paid to the first survivor(s) in this order:

- your spouse (also includes registered domestic partner);
- your children (does not include step-children);
- your parents; or
- your brothers and sisters (including half-brothers and half-sisters).

If there is no surviving relative in any class, the benefit amount will be payable to your estate.

Will Preparation Services

If you elect supplemental life insurance coverage, you and your spouse or registered domestic partner will have access to will preparation services offered by Hyatt Legal Plans, a Metropolitan Life Insurance Company affiliate. When you use a participating attorney, the attorney fees are fully covered for preparing or updating a will, including testamentary trusts within the will, such as trusts for minor children and charitable trusts that take effect after death.

You can call Hyatt Legal Plans at 800-821-6400 and a client service representative will help you locate a participating attorney in your area. You will be asked to provide your Social Security number and PG&E's policy number: 74300.

You also have the flexibility of using a non-participating attorney and being reimbursed for covered services according to a set fee schedule. To be eligible for reimbursement, you must call Hyatt in advance of your consultation, provide PG&E's policy number, and request a case number. However, if you use a non-participating attorney, you must pay the attorney's fee directly, then provide proof of payment to Hyatt, along with a claim for reimbursement. You will be reimbursed for the attorney's services up to the amount you paid for the attorney's services or the amount customarily reimbursed for such services by Hyatt, whichever is less.

Documents such as living wills and powers of attorney are also included in the will preparation service.

Estate Resolution Services

If you elect supplemental life insurance coverage, you and your spouse or registered domestic partner will have access to MetLife Estate Resolution Services at no additional cost to you. A Hyatt Legal Plan attorney will consult with your beneficiaries by phone or in person about the probate process for your estate. The attorney also will handle the probate of your estate for your executor or administrator. These services provide valuable financial and administrative support for your family's probate needs. You can call Hyatt Legal Plans at 800-821-6400 to help you locate a participating attorney in your area. You can also use a non-participating attorney and be reimbursed for covered services according to a set fee schedule.

Accelerated Benefit Option (ABO)

An early cash payment option, called the Accelerated Benefit Option (ABO), is included under the Group Life Insurance Plan. This cash payment option allows an employee, spouse or registered domestic partner who is terminally ill and whose death is expected within one year or less to receive a portion of his or her life insurance coverage. You must have at least $10,000 in Basic, Supplemental or Spouse/Registered Domestic Partner life insurance coverage to qualify for this option.

The following points briefly outline some of the provisions of the Accelerated Benefit Option (ABO):

- Benefits provide a cash payout of up to 80% of life insurance (basic and supplemental) coverage.
- This is a one-time election option.

- The maximum payout amount is $8,000 for Basic Life Insurance, $500,000 for employee supplemental life insurance, and $80,000 for spouse or registered domestic partner supplemental life insurance.
- The balance of life insurance coverage is "frozen" and paid out to the designated beneficiary at the time of the employee's, spouse's or domestic partner's death.
- All decisions made by Metropolitan Life Insurance Company to grant or deny this benefit are final.
- Exclusions:
  - You are not eligible for the ABO if you have assigned your life insurance coverage (see "Assignment of Benefits" under "Group Life Insurance" on page 316 for additional information), or
  - The amount of your benefit is less than $10,000.

For further information about the ABO option, please call Metropolitan Life Insurance Company at 888-878-8490.

Assignment of Benefits

You have the right to assign your life insurance benefits to someone else as a gift or as a viatical assignment, but only when a viatical assignment is allowed by state law. This means you can transfer or assign all rights, title, interest and ownership, both for the present and future which includes:

- the right to make any contributions required to keep the benefits in force,
- the privilege of obtaining an individual policy of life insurance (conversion), and
- the right to designate or change the beneficiary designation.

Assignment of benefits is a complicated financial and legal matter. If you are considering an assignment, please contact Metropolitan Life Insurance Company at 888-878-8490 for additional information.

Viatical Assignment

An option for terminally ill employees is to sell their life insurance for cash to viatical settlement companies that buy life insurance policies. Viatical settlement companies offer different levels of cash payment options and the criteria for qualifying varies from one company to another. You must contact a viatical settlement company directly to obtain information regarding its program options.

For further information about the viatical option, please call Metropolitan Life Insurance Company at 888-878-8490.

Changing the Level of Your Coverage

You can increase or decrease the amount of your life insurance coverage at any time. If you increase coverage, however, you will be required to complete and submit a Statement of Health form to Metropolitan Life Insurance Company for all elections over two times annual pay. If you are not actively at work the change will not become effective until you return to work. See "Actively at Work" under "Eligibility, Enrollment and Cost" on page 317.

If you elect to increase your Group Life Insurance Plan coverage to an option of up to two times your annual pay, the increase is automatically approved by Metropolitan Life Insurance Company, and your cost of coverage will be based on the amount elected.

If you fail to submit evidence of good health, your coverage will be limited to two times your annual pay.

If you make an election or elect any increase in coverage for your spouse or registered domestic partner after the initial 90-day eligibility period, your spouse or registered domestic partner will be required to submit evidence of good health to Metropolitan Life Insurance Company for approval. See "Evidence of Good Health" below for more details.

Evidence of Good Health

During the initial eligibility period, you can elect supplemental life insurance coverage up to two times your base annual pay (and up to $25,000 coverage for a spouse or domestic partner) without evidence of good health. After the initial eligibility period, any requested increase in life insurance above two times your base annual pay (or any election or increase for a spouse or registered domestic partner) requires evidence of good health and approval by Metropolitan Life Insurance Company. If you elect an amount of coverage that requires approval, Metropolitan Life Insurance Company will send you a Statement of Health form which you will need to complete and return. Alternately, a Statement of Health may be completed online as part of the enrollment process.

If Metropolitan Life Insurance Company requires a physical examination in order to make its determination, the examination will be at your own expense. After Metropolitan Life Insurance Company receives complete information from you and your doctor (if required), you will receive notification of Metropolitan Life's decision to approve or deny your request. If you fail to submit evidence of good health, your coverage will be limited to two times your annual pay.

Approval or Refusal

Once MetLife receives the completed form, they will notify you that they are either increasing your coverage to the level you requested, effective on the first day of the month following the approval date, or denying your request.

If approved, your life insurance coverage cost will change the first of the month following approval to reflect the increased contribution.

If your request is denied, your coverage will remain at the amount in effect prior to your request or two times your annual pay, whichever is greater.

What Happens…

If You Take a Leave of Absence

If you are on a Company-approved leave of absence, your Basic Life Insurance coverage will remain in effect for the duration of the leave. Any Employee Supplemental Life Insurance and/or Dependent Life Insurance coverage will remain in effect. See "You Take an Unpaid Leave of Absence" in the *What If…* section.

If You Become Disabled

While you qualify for benefits from the Long-Term Disability Plan, your Basic and Supplemental Life Insurance coverage will continue at no cost to you. Your Dependent Life Insurance coverage will remain in effect as long as you remit payment.

If You Retire

If you retire under the Company's Retirement Plan, you may be eligible for postretirement life insurance. For more information, you can access a copy of the Summary of Benefits Handbook for Retirees and Surviving Dependents online at www.mypgebenefits.com or request a copy by sending an email to hrbenefitsquestions@exchange.pge.com. You can also contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

If applicable, you may also apply to convert any remaining amount of your Group Life Insurance coverage to an individual policy within 31 days of the date on which coverage ends. See "Converting Your Coverage to an Individual Policy" on page 322.

When Coverage Ends

Your Group Life Insurance Plan coverage ends:

- At the end of the month in which you retire;
- At the end of the month in which you cease paying required premiums;
- At the end of the month in which you are no longer considered eligible for benefits;
- At the end of the month in which your employment ends (other than retirement); or
- If the Group Life Insurance Plan is terminated by the Company or the carrier.

Converting Your Coverage to an Individual Policy

If you terminate, retire from the Company, are no longer eligible for union-represented benefits, or your benefits are reduced due to a change in your employment with the Company, you, your spouse or registered domestic partner, and child(ren) covered under supplemental life insurance have the option of converting your lost Group Life Insurance Plan coverage to an individual insurance policy within 31 days after your coverage ends, without having to furnish evidence of good health. This option is called the "conversion privilege."

The new policy will become effective immediately upon approval by Metropolitan Life Insurance Company, as long as you have paid the first premium. To apply for an individual policy, contact MetLife Advice Line at 877-275-6387, Option 1 or contact your local Metropolitan Life Insurance agent at 800-MET-LIFE (638-5433).

If you do not apply to convert your life insurance to an individual policy and your death occurs within the 31-day conversion period, your beneficiaries will be entitled to receive life insurance proceeds for the full amount of coverage which was in effect on your last day of employment.

Accidental Death and Dismemberment (AD&D) Insurance

The Company automatically provides you with $10,000 in Basic Accidental Death and Dismemberment (AD&D) Insurance coverage. You may also purchase Voluntary Accidental Death and Dismemberment (Voluntary AD&D) coverage, which you pay for through after-tax salary deductions.

The amount of AD&D insurance you need may depend on several factors, including your age, family status and other financial resources.

Employee Voluntary AD&D Insurance

You can choose from multiple levels of Voluntary AD&D Insurance coverage, up to a maximum of $1,000,000, as follows:

- AD&D 1 (1 times your annual pay)
- AD&D 2 (2 times your annual pay)
- AD&D 3 (3 times your annual pay)
- AD&D 4 (4 times your annual pay)
- AD&D 5 (5 times your annual pay)
- AD&D 6 (6 times your annual pay)

The voluntary coverage amounts are in addition to the $10,000 of Company-provided Basic AD&D coverage.

Your "pay" means your annualized base rate of pay and does not include overtime or any other special compensation. If your annual pay is not a multiple of $1,000, your AD&D insurance amount will be rounded to the next higher $1,000. You pay for Voluntary AD&D coverage through after-tax payroll deductions.

Enrollment changes are allowed during the year, and benefit coverage continues during periods of an approved leave of absence in accordance with the same rules as life insurance.

Dependent Voluntary AD&D Insurance

You may elect Voluntary AD&D Insurance coverage for yourself, your spouse or registered domestic partner, and child(ren) as follows:

Coverage	Benefit Amount
Spouse or Registered Domestic Partner and Child(ren)	An amount equal to 40% of your Voluntary AD&D Insurance for your spouse or domestic partner and 10% of your Voluntary AD&D Insurance for each child
Spouse or Registered Domestic Partner Only	An amount equal to 50% of your Voluntary AD&D Insurance
Child(ren) Only	An amount equal to 15% of your Voluntary AD&D Insurance for each child
Maximum Spouse Voluntary AD&D Full Amount	$500,000
Maximum Child(ren) Voluntary AD&D Full Amount	$150,000

Eligibility, Enrollment, and Cost

You are eligible to participate in the Voluntary AD&D Insurance plan the first of the month after you have completed six months of employment, and attained regular status, if you are a full-time or part-time union-represented employee of the Company. You are not eligible for this AD&D insurance plan if you are a contractor, agency worker, hiring hall employee, or retired employee. Intermittent employees (except as noted) and other temporary employees who are not expected to become regular employees are also not eligible for coverage.

Enrollment

Your Voluntary AD&D Insurance coverage described in this section will go into effect on the first day of the month following receipt of your elections. For example, if you were eligible to participate on February 1 as a union-represented employee, and you complete the enrollment process on February 15, you would be eligible for Voluntary AD&D Insurance, above the Company provided Basic AD&D, on March 1.

Metropolitan Life Insurance Company will send an enrollment welcome package to your home for response within 90 days of your eligibility date.

If you do not complete the enrollment process when initially eligible, you will be assigned Basic AD&D Insurance coverage in the amount of $10,000. You may increase your level of coverage by enrolling for Voluntary AD&D Insurance coverage at any time during the year. Evidence of good health is not required for Voluntary AD&D Insurance coverage.

You must be actively at work on or after the effective date of your enrollment for coverage changes to take effect (e.g., if you are on sick leave or a leave of absence without pay, any changes to your Voluntary AD&D insurance coverage will not take effect until you return to work).

Actively at Work

"Actively at work" means you are performing all of the usual and customary duties that pertain to your work at the place where it is normally done, or where it is required to be done by your employer.

Cost of Coverage

The monthly cost for Voluntary AD&D coverage is based on a flat dollar rate (not an age-based rate) and on the level of coverage you elect. For coverage costs for yourself, spouse or registered domestic partner, and/or child(ren), refer to your personalized information which is available by logging on to the MetLife website.

How Your Benefit Is Paid

AD&D benefits are paid for covered losses if:

- You are injured in an accident that happens when your AD&D coverage is in effect, or
- Your covered dependent is injured in an accident that happens when AD&D coverage is in effect for that dependent; and
- The accident is the sole cause of injury, and that injury is the sole cause of the covered loss, and
- The covered loss occurs not more than 12 months after the date of the accident.

The amount of AD&D benefit payment is based on the level of coverage you elect and the type of loss that results from an accident, as follows:

Covered Loss	Benefit Amount
Life	Full Amount
Seat belt benefit	10% of the Full Amount up to $25,000
Air bag benefit	10% of the Full Amount up to $10,000
A hand	50% of the Full Amount
A foot	50% of the Full Amount

Covered Loss	Benefit Amount
An arm	75% of the Full Amount
A leg	75% of the Full Amount
Sight of an eye	50% of the Full Amount
Any combination of a hand, a foot, and/or sight of an eye	100% of the Full Amount
Thumb and index finger on same hand	25% of the Full Amount
Speech and hearing in both ears	100% of the Full Amount
Speech	50% of the Full Amount
Hearing in both ears	50% of the Full Amount
Paralysis of both arms and legs (quadriplegia)	100% of the Full Amount
Paralysis of both legs (paraplegia)	50% of the Full Amount
Paralysis of one arm **and** one leg on the same side of the body (hemiplegia)	50% of the Full Amount
Paralysis of one arm **or** leg	25% of the Full Amount

For details on other covered losses, please refer to the MetLife Benefits Plan found at https://www.mybenefits.metlife.com/pg&e.

Beneficiary Designation

For AD&D coverage, there is a separate beneficiary form. If you have questions or would like to request an AD&D Designation of Beneficiary Form, you may contact Metropolitan Life Insurance Company at 888-878-8490 and a form will be sent to you for completion. You can also complete one on-line at https://mybenefits.metlife.com/pg&e/.

It is important that you always keep your beneficiary designations up to date. This is your responsibility. You may change your beneficiary designations at any time. Paper designations and changes are effective on the date you sign the notice. Any beneficiary designation or change will not affect any payment Metropolitan Life Insurance Company makes or actions it takes before the notice of designation or change is received and processed.

No Beneficiary at Your Death

If no beneficiary should survive you, your benefit will be paid to the first survivor(s) in this order:

- Your spouse (also includes registered domestic partner);
- Your children (does not include step-children);
- Your parents; or
- Your brothers and sisters (including half-brothers and half-sisters).
- If there is no surviving relative in any class, the benefit amount will be payable to your estate.

Travel Assistance and Identity Theft Solutions

As part of your Basic Accidental Death and Dismemberment (AD&D) Insurance coverage, you have access to Travel Assistance and Identity Theft Solutions through Metropolitan Life Insurance Company. The new programs are offered at no cost to you.

Travel Assistance

Through a marketing arrangement with Metropolitan Life Insurance Company, AXA Assistance USA, Inc. (AXA) offers you and your dependents medical, travel, legal and financial assistance services, 24 hours a day, 365 days a year, worldwide.

You can access services when faced with an emergency while traveling internationally or domestically when more than 100 miles away from home. With one phone call, you and your dependents (whether traveling together or separately) will be connected to a global network of:

- Over 600,000 pre-qualified providers in more than 238 countries and jurisdictions.
- Air and ground ambulance services.
- Trained multilingual personnel who can advise and assist you quickly and professionally in a travel emergency.

Travel Assistance services include:

- **Medical referrals and appointments:** Your call to the Alarm Center enables you to be referred to English-speaking doctors, hospitals, dentists, or other specialists.
- **Hospital admission guarantee:** In the event that a hospital does not recognize your medical insurance, this travel assistance service will assist in guaranteeing hospital admission for you or your dependents by validating your health coverage and/or advancing funds.
- **Emergency evacuation:** Whenever adequate medical facilities are not available locally, this travel assistance service will provide whatever mode of transport, equipment and personnel necessary to evacuate you or your dependents to the nearest facility capable of providing proper care.
- **Critical care monitoring:** A team of doctors, nurses and other medically trained personnel will stay in regular communication with the attending physician and/or hospital to ensure you or your dependents are receiving proper care at all times
- **Lost document and luggage assistance:** The service coordinates replacing lost documents and passports and provides assistance with locating lost luggage once a claim is filed.

AXA Assistance can be reached at 800-454-3679 inside the United States. See the *Contacts* section of this Handbook for more information.

Identity Theft Solutions

Identity Theft Solutions offers tips on how to prevent identity theft, as well as personal guidance to individuals who are victims of this crime. Services are available to you and your dependents, whether you are at home or on the road. Call the toll-free number on your Travel Assistance and Identity Theft Solutions ID card for:

- **Education and tools:** Educational materials, prevention tool kits and resolution guides to provide information and support.
- **Personal guidance:** Case managers who can connect you to appropriate resolution contacts and provide direction on filing reports and complaints with various departments and agencies.
- **Ease and accessibility:** Access to services whether you are at home or traveling, 24 hours a day/seven days a week.

AXA Assistance can be reached at 800-454-3679 inside the United States. See the *Contacts* section of this Handbook for more information.

Hospital Confinement Benefit

As part of your Voluntary Accidental Death and Dismemberment (AD&D) Insurance coverage, you are eligible for a hospital confinement benefit, which pays an additional benefit if you or a dependent are confined in a hospital as a result of an accidental injury. Benefits begin on your fifth day of confinement and continue for up to 12 months of continuous confinement in the amount of the lesser of 1% of your full amount or $2,500 per month.

Additional AD&D Benefits

As part of your Voluntary Accidental Death and Dismemberment (Voluntary AD&D) Insurance coverage, you are eligible for the following benefits. For details, please refer to the MetLife Benefits Plan found at https://mybenefits.metlife.com/pg&e.

- Brain Damage Benefit
- Coma Benefit
- Child Care Benefit
- Child Education Benefit
- Spouse or Domestic Partner Education Benefit
- Common Carrier Benefit

Exclusions to AD&D Benefits

No benefits will be paid for any loss caused or contributed to by:

- physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- infection, other than infection occurring in an external accidental wound;
- suicide or attempted suicide;
- intentionally self-inflicted injury;
- service in the armed forces of any country or international authority, except the United States National Guard;
- any incident related to:
  - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
  - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  - parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
  - travel in an aircraft or device used:
    - for testing or experimental purposes;
    - by or for any military authority; or
    - for travel or designed for travel beyond the earth's atmosphere;
- committing or attempting to commit a felony;
- the voluntary intake or use by any means of:
  - any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a Physician; or
    - an "over the counter" drug, medication or sedative taken as directed;
  - alcohol in combination with any drug, medication, or sedative; or
  - poison, gas, or fumes; or
- war, whether declared or undeclared; or act of war, insurrection, rebellion or riot.

Exclusion for Intoxication

No benefits will be paid for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

What Happens…

If You Take a Leave of Absence

If you are on a Company-approved leave of absence, your Basic AD&D Insurance coverage will continue at no cost to you for the duration of your leave. Your Voluntary AD&D Insurance coverage will remain in effect. See "You Take an Unpaid Leave of Absence" in the *What If…* section.

If You Become Disabled

While you qualify for benefits from the Long-Term Disability Plan, your Basic AD&D Insurance coverage will continue at no cost to you. Your Voluntary AD&D Insurance coverage will remain in effect as long as you remit payment.

When Coverage Ends

Your Voluntary AD&D Insurance Plan coverage ends:

- At the end of the month in which you retire;
- At the end of the month in which you cease paying required premiums;
- At the end of the month in which you are no longer considered eligible for benefits;
- At the end of the month in which your employment ends (other than retirement); or
- If the Voluntary AD&D Insurance Plan is terminated by the Company or the carrier.

Claims and Appeals for Group Life and AD&D

Metropolitan Life Insurance Company is the Claims Administrator. To report a death or dismemberment and file a claim for benefits under the Group Life Insurance Plan for life insurance benefits or file a claim for AD&D benefits, you or your beneficiary should contact Metropolitan Life Insurance Company at 888-878-8490 to request a claim form. You or your beneficiary should also contact the HR Service Center to notify the Company of your loss or death. You or your beneficiary 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 address on the form.

Metropolitan Life Insurance Company is solely responsible for determining whether the life or AD&D benefit is payable at the initial claim level and at the appeal level. If you have been denied a benefit, you may submit an appeal to Metropolitan Life Insurance Company. The procedures governing initial claims and appeals are further described in this section.

Determinations relating to eligibility under the Group Life Insurance Plan or AD&D Plan are made by Metropolitan Life Insurance Company at the initial claim level and by the Employee Benefit Appeals Committee (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 or AD&D Plans by Metropolitan Life Insurance Company, you may submit an appeal. The procedures governing length of service, status, or membership claims and appeals are further described in this section.

Claims Relating to a Benefit

If your initial claim relating to the payment or denial of a Group Life Insurance Plan benefit has been denied by Metropolitan Life Insurance Company 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 specific reason(s) for the denial of the claim;
- a reference to the Plan provision(s) which apply to the denial;
- a description of any additional material or information necessary from 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.

Appeals

If your initial claim relating to the payment or denial of a 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 specific reason(s) for the denial;
- a reference to the Plan provision(s) 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.

Claims Relating to Eligibility

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 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 specific reason(s) for the denial of the claim;
- a reference to the Plan provision(s) 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.

Appeals

If you are not satisfied with Metropolitan Life Insurance Company's decision regarding your length of service, status or membership in the Plan, you may submit a written appeal to the Employee Benefit Appeals Committee (EBAC).

Send your appeal to:

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

Your appeal to EBAC must be received within 90 days of your receipt of the denial of your claim 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 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:

- the reason(s) for the denial of the claim;
- a reference to the Plan provision(s) 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; and
- an explanation of any voluntary appeal procedures and your right to obtain information about such procedures.

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.

State Legal Notices for Group Life Coverage

The following notices are supplied based on various state requirements. The notices are listed in alphabetical order by state.

California Residents

To obtain additional information, or to make a complaint, contact the Policyholder or the Metropolitan Life Insurance Company claim office shown on the Explanation of Benefits you receive after filing a claim.

If, after contacting the Policyholder and/or Metropolitan Life Insurance Company regarding a complaint, you feel that a satisfactory resolution has not been reached, you may file a complaint with the California Department of Insurance:

California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
800-927-4357 (within California)
213-897-8921 (outside California)

Maryland Residents

The group life insurance policy providing coverage under this policy was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

Business Travel Insurance (BTI)

Business Travel Insurance (BTI) pays a benefit if your death or dismemberment is the result of a covered accident. This benefit is paid in addition to any benefit payable from the Group Life Insurance Plan.

PG&E Corporation has entered into an insurance contract with the Life Insurance Company of North America (LINA) that provides for LINA to assume full responsibility and liability for the determination and payment of benefits. LINA insures the benefits described in this section of the handbook. LINA funds all benefits due under the Plan.

Business Travel Insurance covers you from the day you are hired. Your spouse or registered domestic partner is covered if authorized by the Company to accompany you, at the Company's expense, on a business trip.

Eligibility

You are eligible for BTI coverage if you are a regular-status employee of the Company. You are not eligible for Business Travel Insurance coverage benefit if you are temporary employee, a summer hire, a summer technical intern, or a contract, agency, leased, hiring hall or retired employee. Intermittent employees and other temporary employees who are not expected to become regular employees are also not eligible for coverage.

Business Travel Insurance provides you with extra protection while you are using public transportation to travel on Company business, subject to a few limitations.

How Business Travel Insurance Works

Your BTI coverage begins at the actual start of a trip, whether you leave from your office, your home or another location, whichever occurs last. BTI coverage ends when you return to your home or your office, whichever occurs first.

If you travel to another city and you remain there or are expected to remain there for more than 60 days, for the purpose of this Plan, a change in your permanent work location will be considered to have occurred.

The full benefit is payable in addition to your Group Life Insurance Plan benefit if you die as the result of a covered accident that happens while you are using public transportation to travel on Company business.

Amount of Coverage

Your Business Travel Insurance benefit is equal to three times your annual pay, with a minimum of $125,000 and a maximum of $1,000,000 if you are a full-time employee. There is no minimum benefit if you are a part-time employee. "Annual pay" means 12 times your monthly base rate of pay at the time of the accident. Base pay includes night work incentive pay, but does not include bonuses, overtime or commissions.

If your spouse or registered domestic partner is authorized by the Company to accompany you on a business trip at the Company's expense, he or she is covered for $125,000 (or for the same coverage amount as you, if you are a part-time employee), subject to a few limitations. Please refer to Limitations and Exclusions for further details.

Please note: The BTI eligibility rules for registered domestic partners are slightly different than those for the health care plans. Please contact the PG&E Corporation ERM & Insurance Department at 415-973-8761 for details on registered domestic partner coverage.

Your Beneficiary

Any benefit that is due as a result of a loss other than your death will be paid to you. Unless you specify otherwise, the beneficiary of the BTI death benefit is the same beneficiary designated for the Group Life Insurance Plan. Please refer to "Eligibility, Enrollment and Cost" on page 317. You may designate a specific beneficiary for this BTI plan by requesting a Beneficiary Designation from the PG&E Corporation ERM & Insurance Department at 415-973-8761. If you do not designate a beneficiary, death benefits will be paid to your estate.

Benefits are paid in a lump sum unless you (for losses other than your death), or your beneficiary (after your death), choose installment payments from one of the settlement options offered by LINA at the time payment is due.

BTI Benefits

Business Travel Insurance will pay a benefit if, within 365 days of a covered accident, your injuries result in one of the covered losses listed in the following chart. The amount payable depends on the extent of your injuries.

"Loss" with respect to:

- hands or feet, means actual severance through or above the wrist or ankle joint;
- eyesight, means complete and irrecoverable loss of sight; or
- thumb and index finger, means the actual and complete severance through or above the metacarpophalangeal joints.

Examples of Covered Loss (See Description of Covered Losses in the Policy – page 12)	Benefit Amount
Life	100%
Multiple loss involving both hands, both feet, the sight in both eyes, or any combination of foot, hand and sight loss	100%
Loss of one hand, one foot, or sight in one eye	50%
Loss of a thumb and index finger of the same hand	25%

If you suffer more than one loss from an accident, LINA will only pay for the loss with the larger benefit.

If several employees are involved in a single accident, BTI will limit the total benefit paid to $20,000,000. If the total benefit that would otherwise be payable exceeds that total, the BTI benefit is prorated.

Losses After Age 69

The amount of benefit you or your spouse or registered domestic partner is entitled to receive is reduced if the loss occurs after age 69, as follows:

Age on Date of Loss	Amount of Benefit
70-74	65%
75-79	45%
80-84	30%
85 and Older	15%

For example, if you are age 71 on the date of a covered loss, you will receive 65% of the benefit you would have been entitled to receive if you were age 69.

Exposure and Disappearance

The Plan also covers loss resulting from unavoidable exposure to the elements and arising out of covered hazards.

If, within one year after the disappearance, stranding, sinking or wrecking of a vehicle in which you were an occupant, your body is not found, you will be presumed, subject to all other provisions and conditions of this insurance, to have suffered loss of life.

Limitations and Exclusions

The payment for all losses resulting from a single accident cannot be more than your individual coverage. For example, if an insured person receives a BTI benefit payment because of the accidental loss of a limb and later dies because of the same accident, the maximum benefit payable for both losses cannot be more than the total amount of that person's coverage.

Business Travel Insurance does not pay benefits for any loss related to:

- intentionally self-inflicted injuries, suicide or attempted suicide, regardless of whether you are sane or insane;
- war or acts of war, whether declared or not declared;
- an accident that happens while you are serving on full-time active duty in any armed forces of any country or international authority;
- illness, disease, pregnancy, childbirth, miscarriage, or any bacterial infection other than a bacterial infection of a wound sustained in a covered accident; or
- travel in any vehicle or device for navigation beyond the Earth's atmosphere.

There are also a few limitations that apply to air travel, including boarding and deplaning an aircraft. In general, you are covered only as a passenger for air travel. Specifically, BTI does not cover air travel that occurs:

- in an aircraft that does not have a valid certificate of airworthiness or is flown by someone without a valid license; or
- while an aircraft is being used for any test or experimental purpose; or
- while you are operating an aircraft, learning to operate an aircraft, or serving as a member of the crew; or
- while an aircraft is being operated by, for, or under the direction of any military authority, unless it is a transport-type aircraft operated by the Military Airlift Command (MAC) of the United States or a similar air transport service of any other country; or
- in an aircraft being used for specific activities not directly related to transportation including but not limited to firefighting; pipeline or power line inspection; aerial photography or exploration; or any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on); or
- in an aircraft which is owned or operated by or on behalf of the Company or any of its subsidiary or affiliated companies, a Company employee (or an employee of any of its subsidiary or affiliated companies), or any member of his or her household.

For further information, please call the EORM & Insurance Department at 855-307-8057.

Claims Information

When you are reasonably sure that you are eligible to receive benefits under this Plan, please contact the EORM & Insurance Department at 855-307-8057. A LINA claim form will be sent to you along with claim submittal information (all claims submitted to LINA must be on forms provided by LINA).

Complete the claim form according to directions and return it to the EORM & Insurance Department, 245 Market Street, N4S, San Francisco, CA 94105. If applicable, a certified copy of the insured's death certificate must be included with the completed form.

From the date your notice of claim is received, LINA has 90 days in which to review the claim to determine whether or not benefits are payable in accordance with the terms and provisions of the BTI plan. Under special circumstances, LINA may require an extension of this 90-day period in which case you will receive written notice from LINA, prior to the end of the initial 90 days, informing you of the need for an extension. This extension period allows LINA an additional 90 days to review your claim.

During this period, LINA may require a medical examination, at its own expense, or additional information in order to make a determination on your claim. If additional information is required, you will receive a request, in writing, specifying the nature of the information needed and an explanation as to why it is needed. If a medical examination is necessary, you will be given the time of appointment and the doctor's name and location. It is important to keep any appointments made, since rescheduling exams will delay the claim process.

In the case of an accidental death, LINA may require that an autopsy be performed. The autopsy will be at LINA's expense and only if it is allowed by law.

If you are not notified of the claim status within 90 days and you have not been notified that the extension period has been applied, you may request a review of your claim by following the procedure outlined under Claims Review Procedure.

Once your claim has been approved, you will receive the appropriate benefit from the Life Insurance Company of North America (LINA).

If your claim for benefits is denied in whole or in part, you will receive written notice of such denial within the 90-day period (or 180 days if the extension period is required).

Each written notice of denial will include:

- the specific reason(s) for the denial of the claim;
- a specific reference to the provision(s) of the BTI Plan upon which the denial is based; and
- a notice of your right to have the denial reviewed by LINA.

Claims Review Procedure

If you receive a written notice of denial, you or your duly authorized representative may request a review of the claim by giving written notice to LINA. This request for a review must be made to LINA within 60 days of the receipt of denial. If the request is not made within 60 days, you will be deemed to have waived your right to a review by LINA.

Once LINA receives a request for a review, a prompt review of the claim must take place. You or your authorized representative have the right to review documents that might have a bearing on the claim, including the documents which establish and control the Plan, and to submit issues and comments that you feel might affect the outcome of the review.

Upon completion of a full and complete review, LINA will notify you in writing of the results, citing plan provisions that control the decision. LINA has 60 days to notify you of its decision unless special circumstances require an extension of time. If an extension is required, LINA shall notify you of the need for an extension before the end of the initial 60-day period for completing the review procedure. This means that LINA will have an additional 60 days to notify you of the decision on your denied claim.

LINA is the final authority for approving or denying a claim.

Legal Actions

No legal action can be brought until after 60 days following the date written proof of loss is given to LINA. No action can be brought after three years (five years in Kansas and six years in South Carolina) from the date written proof is required.

Retirement Benefits

The Company offers four benefit plans that help you plan and save for your financial security after your retirement:

- The Pacific Gas and Electric Company Retirement Plan (the "Retirement Plan")
- The PG&E Corporation Retirement Savings Plan for Union-Represented Employees (the "Retirement Savings Plan," or "401(k) Plan")
- The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents
- The Pacific Gas and Electric Company Postretirement Life Insurance Plan

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company, PG&E Corporation, and other affiliated subsidiaries, collectively. The plans and benefits described in this section are applicable to employees of these entities only to the extent that an employer is a plan sponsor or a participating employer with respect to the described plans or programs and such employees meet the eligibility requirements of the plans or programs.

The Retirement Plan is a "defined benefit" plan, which means eligible participants receive a fixed pension benefit that is based on a defined formula reflecting credited service and pay. The Retirement Plan has two pension benefit formulas:

- A Final Pay Pension formula; and
- A Cash Balance Pension formula.

To find out which pension benefit formula applies to you, see the *Retirement Plan at a Glance* section. For a detailed description of each formula, see the *Retirement —Final Pay Pension Benefit* and the *Retirement — Cash Balance Pension Benefit* sections.

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. The Retirement Savings Plan offers two company matching benefits — a company match of $0.60 per dollar on your contributions of up to 3% or 6% of pay, depending on years of service, if you are earning a benefit under the Final Pay Pension formula, or a higher 401(k) company match benefit of $0.75 per dollar on your contributions up to 8% of pay if you are participating in the Cash Balance Pension. To find out more about your Retirement Savings Plan benefits, please refer to the *Retirement Savings Plan* section.

The Health Care Plan for Retirees and Surviving Dependents provides medical, mental health/substance abuse treatment and prescription drug coverage for eligible retirees and their spouses/registered domestic partners and/or dependents. A detailed summary description of the Retiree Medical Savings Account (RMSA) you earn while you are working is included in this section. Additional information on RMSA and retiree medical coverage is available in the *Summary of Benefits Handbook for Retirees and Surviving Spouses* on the **www.mypgebenefits.com** Internet site.

The Postretirement Life Insurance Plan provides eligible retirees with a specific amount of life insurance coverage. A summary description of the Postretirement Life Insurance coverage is included in this section. Additional information is also available in the *Summary of Benefits Handbook for Retirees and Surviving Spouses* on the **www.mypgebenefits.com** Internet site.

The Postretirement Life Insurance Plan provides eligible retirees with a specific amount of life insurance coverage. A summary description of the Retirement Life Insurance coverage is included in this section. For more information about life insurance and administrative information, see the *Life and Accident* section of the Summary of Benefits Handbook. Additional information is also available in the *Summary of Benefits Handbook for Retirees and Surviving Spouses* in the **My Benefit** section of the PG&E@Work for Me intranet.

The Company also makes contributions towards your future Social Security retirement benefits. These contributions are in addition to the deductions for Social Security taxes taken out of your paycheck. Go to **www.ssa.gov** for more information about Social Security benefits.

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.

In This Section

Retirement Plan at a Glance

The Pacific Gas and Electric Company Retirement Plan (the "Retirement Plan") provides eligible participants with a pension benefit, payable as a monthly annuity, that serves as a valuable part of your retirement income. 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, the Retirement Savings Plan and Social Security, all contribute to your financial health in retirement.

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 415-973-4357 or toll-free at 800-788-2363. See "Payment Options" for more information about making your retirement elections. 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 "If You Get Divorced" under the *Final Pay Pension* or *Cash Balance Pension* sections for more information, including important details about submitting your retirement paperwork if you are divorced.

The Retirement Plan Benefit Formulas

When you retire, the Retirement Plan will pay you a pension benefit based on your eligible service and your pay. There are two retirement benefit formulas that may apply, based on your employment date and, in some cases, your benefit election. Both formulas provide a benefit that does not increase with inflation or otherwise once you begin receiving payments. Benefits under the Final Pay Pension are generally payable only as a monthly annuity; you will receive a fixed monthly amount for your lifetime, or for the combined lifetime of you and your spouse or named beneficiary. If you have a Cash Balance Pension account, you have the option to elect a single lump sum payout of your Cash Balance Pension account.

Final Pay Pension Formula

The Final Pay Pension formula applies to PG&E union-represented employees who were participants in the Retirement Plan prior to January 1, 2013. If you are rehired in 2013 or later, you automatically participate in the Cash Balance Pension. Under the Final Pay Pension formula, your pension is determined by your final pay 30 days before you terminate employment and your years of credited service. For more information, see the *Final Pay Pension Benefit* section.

Employees participating in the Final Pay Pension formula who elect to participate in the Cash Balance Pension formula during the one-time pension choice period in 2013 stop earning benefits under the Final Pay Pension formula when the Cash Balance Pension benefits are effective.

Cash Balance Pension Formula

The Cash Balance Pension formula applies to pension eligible PG&E employees hired or rehired on or after January 1, 2013, and employees participating in the Final Pay Pension who elected a Cash Balance Pension during the one-time pension choice period offered in 2013. Under the Cash Balance Pension formula, your pension benefit consists of pay credits plus interest accumulated in your cash balance account over time.

For more information, see the *Cash Balance Pension Benefit* section.

Retirement Plan Highlights

- Participation in the Retirement Plan generally begins on your first day of employment with the Company, including any participating employer; there is no waiting period to begin earning a benefit. See the "Participating in the Plan" subsection in the *Cash Balance Pension Benefit* section and in the *Retirement — Final Pay Pension Benefit* section for information regarding employees of PG&E Corporation and its designated subsidiaries.
- You have a vested right to your Retirement Plan benefits at the earlier of either three years of service (if you have a benefit under the Cash Balance Pension formula) or five years of service (if you only have a benefit under the Final Pay Pension) with the Company, or at age 55. Once vested, you are eligible to receive a fixed benefit at retirement.
- No employee contributions are required.
- If you die while employed, a benefit may be payable to your spouse or named beneficiary. You must complete a Pre-Retirement Beneficiary Designation to name someone other than your spouse as beneficiary, or to designate a secondary/contingent beneficiary.
- At retirement, you can elect monthly pension benefits for your lifetime, or for the combined lifetime of you and your spouse or named beneficiary. With cash balance, you can also elect to receive your cash balance account in a single lump sum payout.
- Once you have started receiving pension benefits, any elections you have made with respect to those benefits are irrevocable, except as noted under the "Changing Your Election" subsection in the *Retirement —Cash Balance Pension Benefit* or *Retirement —Final Pay Pension Benefit* section.
- Xerox HR Services is the third-party administrator engaged by the Plan Administrator to fulfill certain recordkeeping and administrative functions for the Retirement Plan.

See the respective plan descriptions for more details.

Retirement Plan — Final Pay Pension Benefit

The Retirement Plan is a “defined benefit” plan, which means eligible participants receive a fixed pension benefit that is based on a defined formula reflecting credited service and pay. The Retirement Plan has two pension benefit formulas, and this section describes the Final Pay Pension formula.

Benefits under the Final Pay Pension are generally payable only as a monthly annuity; you will receive a fixed monthly amount for your lifetime, or for the combined lifetime of you and your spouse or named beneficiary.

Employees participating in the Final Pay Pension who elect to participate in the Cash Balance Pension during the one-time pension choice period in 2013 stop earning benefits under the Final Pay Pension when the Cash Balance Pension benefits are effective.

In This Section

Final Pay Pension Benefit at a Glance

This is the Summary Plan Description for benefits under the Pacific Gas and Electric Company Retirement Plan (the "Retirement Plan") Final Pay Pension formula for union-represented participants. Separate summary plan descriptions are provided to describe the benefits and eligibility for other Retirement Plan formulas.

- Under the Retirement Plan's Final Pay Pension formula, you earn a pension benefit based on your pay and your years of credited service at retirement.
- Participation in the Retirement Plan for most employees (excluding hiring hall, temporary additional or outage employees) begins on your first day with the Company; there is no waiting period to begin earning a benefit.
- You're 100% vested in your Final Pay Pension after five years of eligible service with the Company or reaching age 55 while an employee of the Company.
- When you retire, you receive a fixed monthly benefit (an "annuity") for life.
- You may retire as early as age 55, but your monthly benefit will be reduced for early retirement, unless you have enough credited service to qualify for an unreduced pension.
- If you retire before age 65 and have at least 30 years of credited service, there is no reduction in your monthly pension benefit for early retirement.

Participating in the Final Pay Pension

- You are eligible to participate in the Final Pay Pension if you were employed in an eligible classification prior to January 1, 2013 by Pacific Gas and Electric Company or any other company, association or credit union formally designated to participate in the Retirement Plan.

Additionally, if you elected to participate in the Cash Balance Pension during the one-time pension choice period offered in 2013, your Final Pay Pension was frozen as of December 31, 2013 and based solely on eligible pay and credited service at the time you ceased to earn additional benefits under this pension formula.

If you terminate employment and are rehired on or after January 1, 2013, you will not participate in the Final Pay Pension upon rehire. Instead, you will participate in the Cash Balance Pension upon return. In certain limited circumstances, such as if you were employed in an eligible classification on December 31, 2012, terminated employment but were rehired during 2013, you are also eligible to participate in the Final Pay Pension and to make a one-time pension choice election. You will be notified if this special rule applies to you.

Automatic Participation

Generally, employees hired prior to January 1, 2013, automatically began to participate in the Final Pay Pension on their first day of work.

You are not eligible to participate in the Final Pay Pension if you:

- are hired or rehired on or after January 1, 2013 (except as noted above);
- elected the Cash Balance Pension during the one-time pension choice period offered in 2013 (in which case your participation in the Final Pay Pension ended on December 31, 2013); or
- are a hiring hall, outage, temporary additional, or intermittent employee under the IBEW Physical Agreement (who has not attained regular status), or any other individual excluded under the terms of an applicable agreement with a union.

Cost of the Plan

PG&E pays the full cost of your Final Pay Pension benefit. You are not required or permitted to make any contributions to the Plan.

How the Final Pay Pension Works

The Plan is designed to provide you with income when you retire from PG&E. Benefits under the Final Pay Pension are based on a formula that takes into account your pay 30 days before your service ends, and length of credited service with the Company. The actual amount you receive from the Retirement Plan will also vary depending on:

- when you choose to retire;
- your age when benefits begin; and
- any joint pension election you choose.

See "Your Pension Benefit" on page 348 for additional information.

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 understanding your pension benefit, you may use the Pension Estimator which is available through the PG&E Pension Center located at https://pgepensioncenter.com or through the PG&E@Work For Me – My Retirement intranet site. The Pension Estimator tool allows you to calculate your estimated monthly benefit based on information and assumptions that you enter.

You may also request a pension estimate by sending an e-mail to the HR Service Center at HRBenefitsQuestions@exchange.pge.com, or you can contact the HR Service Center at 415-973-4357 or toll-free at 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 obtained through the HR Service Center — are not binding and are subject to final review of payroll and employment data, as well as applicable Retirement Plan provisions. If a mistake is made, you will be paid the correct amount, even if that amount is less than the estimated amount.

Your Pension Benefit

The Retirement Plan uses the following formula to determine your Final Pay Pension benefit payable as of the first of the month following your 65th birthday:

Final Basic Weekly Pay Converted to Monthly Equivalent Pay *	×	1.5% × Credited Service Up to 25 Years	+	1.6% × Credited Service Over 25 Years	=	Monthly Pension Benefit

* Basic Weekly Pay is the hourly straight-time rate of pay as of 30 days before retirement/termination date multiplied by 2,080 hours, divided by 52 weeks. This Basic Weekly Pay is then rounded up to nearest $10, multiplied by 52 weeks, divided by 12 months to determine Monthly Equivalent Pay.

The following example illustrates how the formula works. Let's assume you retire at age 65 with 30 years of credited service (for more information, see "Credited Service" on page 349). Let's also assume your basic weekly pay (defined below) and monthly equivalent pay are as follows:

- Basic Weekly Pay as of June 1, 2013 = $1,384.85 ($1,390.00 after rounding)
- Monthly Equivalent Pay = ($1,390.00 × 52 / 12) = $6,023.33

Monthly Equivalent Pay		Formula		Monthly Pension Benefit
$6,023.33	×	{(.015 × 25) + (.016 × 5)}	=	$2,740.62

In this example, your monthly pension benefit payable beginning at normal retirement (age 65) in the form of a single life annuity would be $2,740.62.

Basic Weekly Pay

Your "basic weekly pay" is equal to your straight-time hourly 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 - multiplied by 2,080 hours, divided by 52 weeks, then rounded up to the nearest $10.

This rate of pay is increased:

- by 2.75% for all clerical employees who received the 1988 lump-sum payment; or by 3.75% for clerical employees who received the 1988 and 1989 lump-sum payments; and
- by 4% 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 $1,305.97 for IBEW Clerical employees, and $1,347.95 for all other union-represented employees for calendar year 2014, as 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 Retirement Plan participants who receive shift premiums, Sunday premiums and nuclear premiums. This additional benefit is based on applying the Final Pay Pension formula to the average monthly straight-time premium received in the calendar year before retirement; however, if you elected the Cash Balance Pension during the one-time pension choice period offered in 2013, your additional retirement income will be determined as described above, for the period from January 1, 2013 through December 31, 2013. You must be at least age 55 when your employment ends to receive this benefit.

Credited Service

Generally, as an eligible employee, you begin to earn service credit under the Retirement Plan beginning on your date of hire.

Regardless of any other Retirement Plan provision, you will not earn credited service under the Final Pay Pension on and after the date you cease to be eligible to participate in the Final Pay Pension.

Credited Service After 1975

As a participant, you are given service credit for all periods of continuous employment with the Company and participating employers, including periods when:

- you are on an authorized leave;
- you remain employed and are entitled to receive sick leave pay or benefits from the Company's 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 performing qualified military service (as long as your re-employment rights are protected by law) and return to work;
- you are laid off for lack of work for less than 12 continuous months, if you had less than five years of credited service; or
- you are laid off for lack of work for less than 24 continuous months, if you had five years or more of credited service.

Your credited service will end as of the earliest date on which you quit, retire or are discharged, the date of your death, or the first anniversary of the date you are absent from work for any reason not described above.

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

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). All service as a part-time or intermittent employee prior to January 1, 1991, will be considered full-time service. If you became a part-time employee prior to 1991, your part-time service prior to 2001 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" on page 351.

Credited Service Upon Re-Employment

If your employment with the Company ends and you are rehired after January 1, 2013, you will participate in the Cash Balance Pension going forward. If your rehire date was before January 1, 2013, and in limited circumstances for rehires after January 1, 2013, you may be eligible to receive credit for your past service, provided you have not started to receive your pension benefit. Whether your past service is counted depends upon the following:

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

Generally before January 1, 2013, you did not have a break in service if you returned to work within 12 months after your service ended. In this case, your service was considered continuous and included 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" on page 351 for important information on credited service.

If you left the Company due to termination or retirement, began receiving your pension benefit, and were rehired before 2013, you began to accrue a new Final Pay Pension benefit from the date of rehire. If you are rehired on or after January 1, 2013, you will begin to earn a new benefit under the Cash Balance Pension. Your prior service will not be recognized for Final Pay Pension benefit purposes, but will be recognized for purposes of determining eligible pay credits under the Cash Balance Pension. See "How the Cash Balance Pension Works" for more information.

Vesting

You are 100% vested in the value of your Final Pay Pension benefit at the earliest of the following events:

- attaining age 55 while an employee of the Company; or
- completing five or more years of service; or
- completing three or more years of service if you are earning a benefit under the Cash Balance Pension formula.

For vesting purposes, service includes the period of time beginning with the first day you are employed with the Company and generally continues through the date when you terminate employment with the Company. If you terminate employment with the Company before vesting, you will lose your right to receive Retirement Plan benefits.

Breaks in Service

A break in service may affect your credited service for pension calculation purposes. 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 when your employment ended, your credited service before the break will be counted. If you had less than five years of credited service, your credited service before the break will be canceled unless the break in service was shorter than five years.

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

If you had at least 10 years of credited service when your employment ended, your credited service before the break will be counted. If you had less than 10 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 when your employment ended, 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 at the time your employment ended.

In addition, if you were a participant before 1973, 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.

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.
- 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.

When Benefits Are Payable

Benefits are payable at the earliest of the following:

- When you elect to commence benefits at Early, Normal or Deferred Retirement:
  - Normal Retirement — refers to retirement at age 65. Your normal retirement date is the first day of the month after your 65th birthday and is the date you can receive an unreduced benefit from the Plan
  - 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 to start your early retirement benefits. The shorter your service, the less you will receive from the Retirement Plan. See "Early Retirement Benefits" on page 352 for details.
  - Deferred Retirement — refers to retirement after 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. See "Deferred Retirement Benefits" on page 353 for details.

- If you die before you begin receiving pension payments, your surviving spouse or named beneficiary can generally start their Pre-Retirement Survivor's Pension benefit as of the later of the date of your death or the month that you would have attained age 55. See "If You Die Before You Retire" on page 360 for details.
- If you are a former employee with a vested benefit and reach the age of required minimum distributions of your Final Pay Pension benefit as required by federal law (age 70½) you must start your benefit payments. See "If You Leave the Company with a Vested Benefit and Want to Start Your Pension" on page 358 for details.
- If you are a former employee with a vested benefit subject to mandatory distribution. See "Mandatory Distributions" on page 354 for details.

If you have both a Final Pay Pension and a Cash Balance Pension, your election to commence benefits under the Final Pay Pension is independent of your election to commence benefits under the Cash Balance Pension.

Starting Your Pension Payments

If you are seriously considering retirement in the near future, you must notify the HR Service Center at least 90 days before your proposed pension payment start date. You must submit a completed Pension Election Form and supporting documentation to the HR Service Center at least 30 days before your pension start date in order to commence your pension benefit. To allow for calculation and final processing of your benefit, your first pension payment will be paid the first of the month following your pension start date and will include both the first and the second month benefit payments. Please note that if you delay the start of payments from the Retirement Plan, the amount of your payments may increase. You should consider consulting a financial advisor before electing to start your pension payments.

Early Retirement Benefits

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 start payments. 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.

Reduction Percentage

Age	Reduction in Your Pension if Your 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 additional month of age 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%. Each month of age past 55 will decrease the reduction factor. At age 55 years and four months, the reduction factor would be 29%, and so on. While reduction factors change for each month of age between birth dates, they do not change for additional months or years of credited service until you move into a new service band, as illustrated in the table. For example, if you are age 55 and four months with 16 years of service, the factors are the same as for someone at age 55 and four months with 23 years of service.

These reductions assume that your pension starts on the first day 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 × .26) = $740
Delayed to age 60	$1,000 per month	6%	$940 per month $1,000-($1,000 × .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

Deferred Retirement Benefits

If you continue working past your normal retirement age (age 65):

- 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. You may elect to begin payment of your pension benefit when you actually retire. See "When Benefits Are Payable" on page 351 for additional information.
- If you elect deferred retirement or to defer receiving your pension benefit after you have retired, your monthly pension benefit will be actuarially adjusted to reflect the shorter period of time you are likely to be receiving a pension. The amount of this increase will be offset by any additional pension benefit you earn under the Retirement Plan with each year of service after age 65 as long as you have not begun receiving payments.

See "Minimum Distributions" on page 354 for additional information on legally required minimum distributions when you reach age 70½.

Benefits If You Leave PG&E Before Age 55

If you leave PG&E before age 55 with at least five years of service (or at least three years of service if you also have a Cash Balance Pension), you are entitled to a vested benefit from the Retirement Plan. Service is defined in "Vesting" on page 350. You may elect to begin receiving your Final Pay Pension on the first day of any month after reaching age 55. See "If You Leave the Company with a Vested Benefit and Want to Start Your Pension" on page 358 for information about starting your benefit payments.

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 ended employment on or after reaching age 55.

If you terminate employment before age 55 without a vested benefit, you will not be entitled to a benefit under the Final Pay Pension. If you are rehired by the Company after a break in service of less than five years, your credited service prior to your severance from service date will be reinstated. If you are rehired after a break in service that equals or exceeds five years, your prior service will not be recognized for Final Pay Pension benefit purposes, and you will begin to accrue a new pension benefit from the date of rehire. If you are rehired on or after January 1, 2013, any new pension benefits you earn will be under the Cash Balance Pension formula.

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 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 remain employed with the Company past age 70½, you will not be subject to minimum distributions until your actual retirement date (subject to changes in tax law).

If you are subject to the minimum distribution requirements, the Plan Administrator will calculate the amount of your benefit that will satisfy the minimum distribution requirement for the Retirement Plan. If you participate in other plans, including the PG&E Corporation Retirement Savings Plan or any personal IRAs, the minimum distribution requirements for those plans or retirement accounts must be satisfied independently of the requirements for the Retirement Plan.

Mandatory Distributions

If you have a vested benefit from the Retirement Plan and the lump sum present value of your pension benefit (including any benefits payable under the Cash Balance Pension) is less than $5,000 as of the date your employment ends, you must take distribution of the lump sum value of your benefit. 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. If you do not make an election and the lump sum present value of your Retirement Plan benefit is:

- Less than $1,000, you will automatically 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 in your name to an individual retirement account (IRA) selected by the Plan Administrator.

The “present value” is the actuarial equivalent of your Final Pay Pension payable at your normal retirement date if you leave the Company before age 55, or the actuarial equivalent of your benefit at actual retirement date. The present value of your Cash Balance Pension, if applicable, is the vested account balance as of the date your employment ends. You will receive a written explanation about rollover options prior to receiving your distribution from the Retirement Plan.

Pre-Retirement Survivor’s Pension

If you die before your Final Pay Pension payments begin, your surviving spouse or beneficiary is entitled to a benefit (a “Pre-Retirement Survivor’s Pension”). For more information, see “If You Die Before You Retire” on page 360.

Payments to a Lost Participant or Beneficiary

It is your responsibility to keep your contact information on file with the Plan Administrator to ensure that the Plan Administrator can reach you regarding your pension benefits. In the event that you or your beneficiary cannot be located on the latest date upon which your Final Pay Pension benefits must start, your benefits will be forfeited and used to reduce the cost of the Plan to the Company. If you’re later located, your benefits will be reinstated without any earnings or interest adjustment.

Payment Options

When you retire, you choose how to receive your pension benefit. The Retirement Plan offers a number of annuity options, including some that continue payments to your spouse or other beneficiary in the event of your death. Your elections are made on your Pension Elections Form. Payment option elections under the Final Pay Pension are independent of any payment option elections you make under the Cash Balance Pension.

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 start date. If your completed paperwork is not received on time (at least 30 days before your requested pension start 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 pension benefit date is May 1, 2013, and your completed paperwork is received on April 10, 2013, your new pension benefit date will be recalculated for June 1, 2013. The Retirement Plan does not allow retroactive payments.

If you are:

- divorced or divorcing, see "If You Get Divorced" on page 359 for more information, including important details about submitting your retirement paperwork if you have a Qualified Domestic Relations Order, or "QDRO."
- unmarried at the time you begin receiving payments from the Retirement Plan, the default is 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 begin receiving payments from the Retirement Plan, federal law requires that you be paid at least a 50% joint pension with your spouse as the joint pensioner (a "Marital Pension"). This form of benefit will, upon your death, continue making benefit payments to your spouse for your spouse's lifetime based on 50% of the payment amount during your life. If you elect continued payments of less than 50% for your spouse, or elect a joint pension with someone other than your spouse, both you and your spouse must sign the Pension Elections Form, and your signatures must be witnessed by a Notary Public. For purposes of the Retirement Plan, you have a "spouse" if you are legally married under applicable law of a state or foreign jurisdiction, including a same-sex couple. However, in accordance with IRS guidance, a registered domestic partnership, civil union, or other similar formal relationship that is not denominated as a marriage under the law is not treated as legally married for purposes of the Plan.

Single Life Pension

You may elect to receive your pension payable for your lifetime only and 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 signatures 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% 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 based on your age and the age of your joint pensioner on your pension commencement date. This reduction is necessary because payments are guaranteed for two people and are likely to be paid for a longer period of time.

Here's an example:

Example of 50% Joint Pension

- Employee is age 65; joint pensioner is age 62
- Basic monthly pension is $1,655.40
- Employee elects a 50% 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 × $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 × 50% = $783.83

Joint pensions are available at 25%, 50% (the default Marital Pension for married employees), 75% and 100% 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% may not be available for you to elect). If you are married and you elect continued payments of less than 50% for your spouse, or you elect a joint pension with someone other than your spouse, both you and your spouse must sign the Pension Elections Form, and your signatures 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.

You may elect a Special Joint Pension that provides for a payment of 25%, 50%, 75% or 100% of your reduced benefit to your joint pensioner after your death. If you are married and you elect a Special Joint Pension with someone other than your spouse, or continued payments of 50% or less for your spouse, both you and your spouse must sign the Pension Elections Form, and your signatures must be witnessed by a Notary Public.

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.
- If you and your joint pensioner (if applicable) die before receiving total payments equal to or greater than your contributions plus interest, the difference between the amount of your contributions plus interest and the total payments received will be paid to your beneficiary (or the beneficiary of your joint pensioner, if applicable).

Tax Implications

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.

Changing Your Election

Once you elect a payment option, you may change your election 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 prior to your pension date.

Once you have submitted your completed paperwork and your pension date has passed, all of your elections are irrevocable. For instance, if you are receiving a pension benefit that continues a benefit to your spouse and your spouse dies before you do, your pension amount will not be increased unless you elected the special joint pension ("Pop-Up" pension) with your spouse. Your joint pension may not be transferred to another person, even if you remarry.

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 unless you elect otherwise. See "If You Die Before You Retire" on page 360 for details.

Facility of Payment

If you are entitled to any payment under the Plan, and the Plan Administrator determines that you are physically or mentally incompetent and no guardian or conservator has been appointed to receive your payment, the Plan Administrator may make payments on your behalf to a third-party to be applied for and on behalf of and for your benefit. Payments made on your behalf will completely discharge the Plan's responsibility for the amount of the payment.

No Guarantee of Employment

Participation in the Plan does not guarantee your right to employment with PG&E or any affiliates. Further, nothing set forth in this Summary Plan Description should be interpreted to give you or your beneficiary any legal or equitable rights against PG&E.

Military Service

Federal law provides rights to certain reemployed veterans for service credit, including for purposes of benefit accruals in certain situations, for periods of military service. Please contact the HR Service Center for more information.

Your Responsibility to Maintain a Current Address

You will receive periodic information regarding your Retirement Plan benefits. After your employment ends, you will receive periodic information about your vested benefit under the Retirement Plan. It is your responsibility to notify the Plan Administrator of any changes in your home address. To change your address, contact the HR Service Center at 415-973-4357 or toll-free at 800-788-2363.

If correspondence regarding your plan benefits is returned as undeliverable, the Plan Administrator will make efforts to locate you, including engaging the services of third-party address search services. If the Plan Administrator is unable to locate you on the latest date upon which your Final Pay Pension must start, your benefit under the Plan will forfeited and used to offset future employer contributions. If a proper claim is later presented, your benefit will be reinstated without any earnings or interest adjustment.

Borrowing, Pledging, and Assigning Interests in the Plan

No participant or beneficiary may borrow against, pledge, or assign — voluntarily or involuntarily, or by operation of law — any interest in the Retirement Plan or in any distribution to be made under the Retirement Plan. However, this does not prevent a spouse, former spouse, child, or other dependent of an employee to claim an interest in an employee's Retirement Plan benefits under a QDRO issued by a court (see "If You Get Divorced" on page 359). Generally, except as described above, no party, including creditors of PG&E, has or may create a lien on your benefit under the Retirement Plan.

What Happens…

If You Leave the Company with a Vested Benefit and Want to Start Your Pension

If you leave the Company with at least five years of service (or at least three years of service if you also earned a Cash Balance Pension) 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 future Final Pay Pension benefit from the Retirement Plan when you reach retirement age. You can elect to begin receiving your Final Pay Pension benefit at any time on or after the first day of the month following your 55th birthday. Different terms apply for the Cash Balance Pension; see "If You Leave the Company With a Vested Benefit and Want to Start Your Pension" in the *Retirement – Cash Balance Pension Benefit* section for more information. If you elect to start your pension payments before age 65, your *Final Pay Pension* benefit payable at age 65 will be reduced for early commencement, depending on your years of service and age as of your pension start date, using the appropriate early retirement reduction factor. You may also elect a joint pension, as described in "Joint Pension" on page 355.

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 Benefits" on page 352). However, benefit payments must begin no later than April 1 of the year after you reach age 70½.

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. It is your responsibility to notify the HR Service Center in writing 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 "When Benefits Are Payable" on page 351 for important information on payment provisions.

It is your responsibility to keep your updated contact information on file with PG&E current to ensure that the Plan Administrator can reach you regarding your pension benefits. In the event that you or your beneficiary cannot be located on the latest date upon which your Final Pay Pension benefits must start, your benefits will be forfeited and used to reduce the cost of the Plan to PG&E. If you're later located, your benefits will be reinstated, without any earnings or interest adjustment.

If You Transfer to or from a Non-Union Position

Under the Retirement Plan, different benefit provisions apply to non-union represented Management and Administrative & Technical (A&T) employees (Part 1 of the Retirement Plan) than apply to union-represented employees (covered under Part 2 of the Retirement Plan). If you transfer to a non-union position or if you have transferred from a non-union position and you have accrued credited service under both Part I and Part 2 of the Plan, your pension benefit will be the larger of:

- the amount resulting from calculating *all* credited service under the benefit formula that applies for your current Management or Administrative & Technical (A&T) position, or
- the benefit amount for your credited service in your union classification under the Part 2 benefit formula added to the amount calculated under the Part 1 formula based on your non-union credited service. The amount for each portion of the benefit will be calculated using pay and all other benefit provisions and reduction factors applicable to the part of the Plan in which credited service was earned — including but not limited to factors for age, early retirement, joint pension, marital pension, and the election of an alternative spouse's pension.

Your retiree status will be associated with the last classification that you held before your employment ends and pension payments begin. For example, if you had union-represented service, transferred to a management position and subsequently retired, you would be considered a management retiree.

If You Get Divorced

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, or a free sample QDRO and QDRO procedures, you can contact the HR Service Center at 415-973-4357 or 800-788-2363 or e-mail HRBenefitsQuestions@exchange.pge.com.

If you are ready to retire or begin your pension and your divorce is final 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 QDRO 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.

If you have both a Final Pay Pension and a Cash Balance Pension, and you have an existing QDRO relating to your Final Pay Pension, you and your ex-spouse may provide a revised QDRO that addresses both benefits. If you choose not to do that, the existing QDRO will apply to both of your benefits — your frozen Final Pay Pension and your Cash Balance pension — as interpreted by the Plan Administrator or its delegate.

If You Die Before You Retire

The Retirement Plan may provide a pension benefit for your spouse or registered domestic partner, or any designated beneficiary, if your death occurs before you retire. If eligible, the amount of your Pre-Retirement Survivor's Pension benefit will depend on your age, years of credited service and employment status at the time of your death. If you are unmarried and die without a designated beneficiary, your Retirement Plan benefit will be forfeited. For purposes of the Retirement Plan, you have a "spouse" if you are legally married under applicable law of a state or foreign jurisdiction, including a same-sex couple. However, in accordance with IRS guidance, a registered domestic partnership, civil union, or other similar formal relationship that is not denominated as a marriage under the law is not treated as legally married for purposes of the Plan.

Designating A Beneficiary

You must complete a Pre-Retirement Beneficiary Designation Form if you wish to name a primary, secondary or non-spouse/contingent beneficiary for your Retirement Plan benefit in the event you die before you retire. If you also have a Cash Balance Pension, you must make a separate beneficiary election for your cash balance benefit. Contact the HR Service Center or visit the PG&E@Work intranet site to obtain appropriate forms.

You will receive a notice that describes your right to designate a pre-retirement beneficiary. If you're married, that notice describes your right to designate a non-spouse beneficiary to receive a pre-retirement survivor's pension—and your spouse's right to consent to such election.

If you participate in the Plan's Cash Balance Pension benefit, the non-spouse beneficiary you designate for your Final Pay Pension benefit may be different than the non-spouse beneficiary you choose for your Cash Balance Pension benefit.

Note for all survivor's benefits described below, if the present value of the pension benefit payable to your spouse or beneficiary is less than $5,000, the benefit will be paid as a single cash payment. See "Mandatory Distributions" on page 354 for more information.

Pre-Retirement Survivor's Pension A

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

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

your survivor is entitled to a pension benefit equal to 50% 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. Pension benefits will be reduced by .05% for each month that your survivor is more than ten years younger than you. However, if your survivor is your spouse, the total reduction cannot result in a smaller pension benefit than what your spouse would have received under a 50% joint pension with applicable early retirement reductions.

The Pre-Retirement Survivor's Pension A is payable on the first day of the month after your death and continues for the life of your surviving spouse or beneficiary.

Pre-Retirement Survivor's Pension B

If you have at least five years of service when your death occurs, and if your survivor does not qualify for Survivor's Pension A, your survivor will be entitled to a pension benefit calculated under the formula for Survivor's Pension B, as follows:

- **For an Employee Who Dies Before Age 55 —** Your survivor will be entitled to a 50% joint pension. This benefit will be calculated as if you had terminated employment on the date of your death.

  Your survivor will begin receiving this benefit on the first day of the month after you would have reached age 55 unless he or she elects otherwise. If your survivor was not your spouse, his or her benefit must commence no later than December 31st of the calendar year after the calendar year of your death, even if that date occurs before the date that you would have reached age 55. The survivor's pension is actuarially adjusted to reflect your age and the survivor's age as of the benefit start date.

- **For a Former Employee Who Dies Before Age 55 —** Your survivor's benefit will be calculated as if you had survived until age 55 and elected a 50% joint pension. Your survivor will begin receiving this benefit on the first day of the month after you would have reached age 55 unless he or she elects otherwise. If your survivor was not your spouse, his or her benefit must commence no later than December 31st of the calendar year after the calendar year of your death, even if that date occurs before the date that you would have reached age 55. The survivor's pension is adjusted to reflect your age and the survivor's age as of the benefit start date.
- **For a Former Employee Who Dies at Age 55 or Older —** Provided you have not yet begun receiving pension payments from the Plan, your survivor's benefit will be equal to the 50% joint pension that would have been payable to your joint pensioner, had you made such an election as of the first of the month following your death. The benefit is effective the first day of the month following the month in which your death occurs unless the survivor elects otherwise. If your survivor was not your spouse, his or her benefit must commence no later than December 31st after the year of your death.

If You Die Within 30 Days of Your Retirement Date

If your death occurs within 30 days of your retirement date, you have submitted completed retirement paperwork to PG&E, and:

- **You are married and have elected a joint pension with your spouse**, your spouse will receive the greater of the joint pension you have elected or the Pre-Retirement Survivor's Pension, described above.
- **You are not married and have elected a joint pension with someone who is not on your Pre-Retirement Beneficiary Designation Form, or you are married and have elected a joint pension with someone other than your spouse**, your joint pensioner will receive the greater of the joint pension or the amount of the Pre-Retirement Survivor's Pension.
- **You are single and you have elected a joint pension with your pre-retirement beneficiary**, your beneficiary will receive the greater of the joint pension you have elected or the Pre-Retirement Survivor's pension.

If You Want to Begin Receiving Your Pension Benefit

If you're retiring, or you are a former employee and want to begin receiving your vested pension 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 paperwork will include a Pension Elections Form, on which you'll indicate your employment end date, pension benefits commencement date, and desired payment option. To help you make the best decision for your needs, the HR Service Center and Xerox HR Services will provide you with an estimate of the pension amounts you would receive under the various payment options available from the Plan. Keep in mind that some payment options require written spousal consent.

Your completed Pension Elections Form and supporting documents must be received by the HR Service Center at least 30 days prior to your pension benefit commencement date. 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 pension benefit date is May 1, 2014, and your completed paperwork is received on April 10, 2014, your new pension benefit date will be recalculated for June 1, 2014. The Retirement Plan does not allow retroactive payments.

Once you have submitted your completed paperwork, all of your elections are irrevocable, except your payment option as provided under "Changing Your Election" on page 357.

If You Are Rehired

If you are a participant in the Final Pay Pension, terminate employment with PG&E, and are rehired on or after January 1, 2013, you will automatically participate in the Cash Balance Pension. This is true even if you were an employee during the one-time pension choice period and did not elect to participate in the Cash Balance Pension.

If you're not vested when your employment ends, your service and benefit will be forfeited if the break in service exceeds five years. If the break in service is less than five years, your credited service and benefit will be restored. Your past service and service after rehire will be considered to determine vesting in your Retirement Plan benefits. If you are vested when your employment ends, your service will be restored regardless of the length of the break.

If You Also Have a Cash Balance Pension

Two types of employees may also have a benefit under the Cash Balance Pension — an employee who elects the Cash Balance Pension during the one-time pension choice period in 2013, and an employee who is re-hired in 2013 or later.

If you elect the Cash Balance Pension during the one-time pension choice period in 2013, your total Retirement Plan benefit will have two components:

- your accrued Final Pay Pension benefit as of December 31, 2013 payable as a monthly annuity; plus
- your accrued Cash Balance Pension benefit from January 1, 2014, through the end of your PG&E employment (which can be paid to you as a lump sum or as an actuarially equivalent annuity).

If you are a rehired employee and earned a Final Pay Pension during your prior period of employment, your Retirement Plan benefit will have two components:

- your accrued Final Pay Pension benefit earned as of your last day of employment before your first rehire date on or after January 1, 2013 (payable as a monthly annuity); plus
- your accrued Cash Balance Pension benefit from your date of re-hire, through the end of your PG&E employment (which can be paid to you as a lump sum or as an actuarially equivalent annuity).

For details about your Cash Balance Pension, see the *Retirement – Cash Balance Pension Benefit* section.

If Your Benefit Is Affected by IRS Limits

The Internal Revenue Code (IRC) and ERISA impose limitations on benefits provided under the PG&E Retirement Plan, both alone and in conjunction with other plans sponsored by PG&E. Generally, these limitations affect only the benefits of certain highly compensated employees. The Plan Administrator will notify you if you are affected by these limits.

If the Retirement Plan becomes less than 60% funded, payment restrictions may apply and, subject to applicable IRC requirements, all Retirement Plan participants will automatically cease to earn any additional Retirement Plan benefits. The Plan Administrator will notify you if you are affected by these restrictions.

Claims and Appeals

Requesting Benefit Payments

To receive a benefit from the Retirement Plan, you generally must complete a Pension Elections Form and provide any additional information needed to process your request and withhold taxes. If you disagree with the response to your request for benefits, whether in whole or in part, and believe you may be entitled to benefits under the provisions of the Retirement Plan, you have the right to pursue your claim for benefits through the Retirement Plan's Claims Procedures. You also have the right to file suit in a Federal court once you have exhausted all steps of the Retirement Plan's Claims Procedures.

Formal Benefit Claims Procedures

To make a formal claim for benefits, you must submit your claim to the Benefits Department within at least 60 days after you first receive the information on which your claim is based 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 claim for benefits; 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, and after exhausting your administrative remedies under the Plan.

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 instead of the appeals procedures described above.

If you are not satisfied with the Benefit Department's decision, you may then submit a written appeal for review (within 90 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 union-represented 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.

The administrative remedies described in this section (as well as a grievance or adjustment procedure of the appropriate collective bargaining agreement if it is used instead of the appeal rights described above) must be exhausted before any legal action can be taken by a claimant. If a claimant timely exhausts all levels of appeal available to the claimant under the Plan's claims procedures (including appeals to both the Plan Administrator and the EBAC), any permissible legal action under ERISA section 502(a) must be initiated within the applicable statute of limitations. The review procedures described in this section are the exclusive administrative procedures provided under the Plan.

The Pension Benefit Guaranty Corporation

Your pension benefits under the Retirement Plan are insured by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under a terminated plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- normal and early retirement benefits;
- disability benefits if you become disabled before the pension plan terminates; and
- certain benefits for your survivors.

The PBGC generally does not cover:

- benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates;
- some or all of the benefit increases and new benefits based on plan provisions that have been in place for fewer than five years at the time the plan terminates;
- benefits that are not vested because you have not worked long enough for the company;
- benefits for which you have not met all of the requirements at the time the plan terminates;
- certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and
- non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money you plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington DC 20005-4026 or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at http://www.pbgc.gov.

Or contact:

Pacific Gas and Electric Company
Benefits Department
1850 Gateway Boulevard, 7th Floor
Concord, CA 94520
415-973-4357 or 800-788-2363

Tax Considerations

All Plan distributions are considered taxable income and are subject to normal federal and (if applicable) state and/or local income taxes.

Annuity payments are subject to income tax withholding at ordinary income tax rates.

If you elect a lump-sum payment to be paid to you, the Company must withhold 20% federal tax from your distribution unless you elect a direct rollover. This withholding is sent to the IRS and is credited as part of your tax withholding for the year in which you receive your distribution.

If you're under age 59½ and don't roll over your lump-sum payment to an Individual Retirement Account (IRA) or other tax-qualified retirement plan, your distribution may be subject to a 10% federal income tax penalty in addition to the 20% withholding tax. State income tax penalties may also apply. However, the additional 10% IRS penalty does not apply if your payment is:

- paid to you because you leave the Company during or after the year in which you reach age 55;
- paid to you after you're permanently and totally disabled;
- paid to you as equal (or almost equal) payments over your life expectancy (or you and your beneficiary's combined life expectancies);
- used to pay certain medical expenses; or
- paid to your beneficiary after your death.

Tax laws are complicated and subject to frequent change. You should consult a qualified tax advisor before making your distribution election.

Retirement Plan — Cash Balance Pension Benefit

The Retirement Plan is a “defined benefit” plan, which means eligible participants receive a fixed pension benefit that is based on a defined formula reflecting credited service and pay. The Retirement Plan has two pension benefit formulas, and this section describes the Cash Balance pension formula.

Benefits under the Cash Balance formula are based on your accumulated pay and interest credits, and are payable as a lump sum payment or a monthly annuity payable for your lifetime, or for the combined lifetime of you and your spouse or named beneficiary.

Employees who elected to participate in the Cash Balance Pension formula during the one-time pension choice period in 2013 stopped earning benefits under the Final Pay Pension formula when the Cash Balance Pension benefits are effective.

In This Section

Cash Balance Pension Benefits at a Glance

- Under the Pacific Gas and Electric Company Retirement Plan's Cash Balance Pension formula, you earn a pension benefit through a growing account.
- On the last day of each year, your individual cash balance account is credited with **pay credits** based on a point system of age plus service and your eligible pay during the year.
- At the end of each calendar quarter, your individual cash balance account is credited with **interest credits**, based on an average of the 30-year Treasury rates for the three months before the calendar quarter.
- You're 100% vested in the value of your cash balance account after three years of service with the Company or upon reaching age 55 while an employee.
- You can receive your full vested account balance at any time after you leave PG&E (whether before or after retirement).
- When you leave PG&E, you can choose:
  - a lump-sum payout that is eligible for rollover into an IRA or other qualified employer plan; or
  - a monthly annuity for your life, or for the combined lifetime of you and your spouse or named beneficiary.

Enhanced 401(k) Match

As a participant in the Cash Balance Pension, you are eligible for a higher 401(k) company match benefit under the PG&E Corporation Retirement Savings Plan of $0.75 per dollar on your contributions up to 8% of pay. See the summary on your Retirement Savings Plan benefits for more information.

Participating in the Cash Balance Pension

You are eligible to participate in the Cash Balance Pension if you are:

- employed by Pacific Gas and Electric Company, PG&E Corporation or any other company formally designated to participate in the Retirement Plan (collectively, "PG&E" or "the Company"), and
- hired or rehired by PG&E on or after January 1, 2013, or
- an employee participating in the PG&E Retirement Plan on December 31, 2012 who elected to participate in the Cash Balance Pension during the one-time choice period offered in 2013.

Automatic Participation

Eligible employees hired or rehired on or after January 1, 2013, automatically participate in the Cash Balance Pension beginning on the first day of work.

If you are an existing eligible employee prior to January 1, 2013, and you elect to participate in the Cash Balance Pension during the one-time pension choice period offered in 2013, your participation in the Cash Balance Pension generally begins January 1, 2014 and your pension benefit under the Final Pay Pension formula is frozen as of December 31, 2013. Your frozen Final Pay Pension will be based on your eligible pay and credited service as of December 31, 2013, or the day before you begin to earn a benefit under the Cash Balance Pension, if later; it will not reflect changes in pay or additional credited service after that date. You are not eligible to participate in the Cash Balance Pension if you are:

- a hiring hall employee;
- an outage employee;
- a temporary additional (under the IBEW Physical Agreement); or
- an intermittent employee under IBEW Physical Agreement (who has not attained regular status); or
- any other individual excluded under the terms of an applicable agreement with a union.

Cost of the Plan

PG&E pays the full cost of your Cash Balance Pension benefit. You are not required or permitted to make any contributions to the Plan.

How the Cash Balance Pension Works

When you first become eligible for the Retirement Plan's Cash Balance Pension benefit, a cash balance account is set up in your name. The amount credited to your account will grow over the course of your employment with PG&E through pay and interest credits. Please note that your cash balance account is a notional account that, once you are vested, is payable from the assets of the Retirement Plan trust when your employment ends. You can review your Cash Balance Pension benefits online by visiting My Retirement section of the PG&E@Work for Me intranet site (effective January, 2014)

If you leave PG&E for any reason, your benefit will be the vested balance in your cash balance account. You decide whether to receive that benefit as a monthly annuity for life or as a lump sum eligible for rollover into an IRA or another qualified plan, or to defer payment to a later date.

If you were hired before 2013 and have earned a benefit under the Final Pay Pension, your election to commence benefits under the Cash Balance Pension is independent of your election to commence benefits under the Final Pay Pension.

Pay Credits

Under the Cash Balance Pension formula, your cash balance account is credited on the last day of each year with pay credits. The amount of your annual pay credit is based on "points," which are a combination of your years of service and age. The table below shows the Plan's pay credit schedule:

Annual pay credits based on points (age + service):	
Fewer than 40 points	5% of pay
40-49 points	6% of pay
50-59 points	7% of pay
60-69 points	8% of pay
70-79 points	9% of pay
80 or more points	10% of pay

For the purpose of determining annual pay credits, attained age and years of service, with both age and years each expressed as whole numbers, are set as of the effective date pay credits are added to your account. For example, if you have worked for PG&E for 7 years, 9 months and are age 55½, you have 62 points (7 years of service plus 55 years of age). Service includes the period of time beginning with the first day you are employed with PG&E and generally continues through the date you terminate employment with PG&E. Service includes past service through 2013 also recognized under the Final Pay Pension formula. There is no credit for partial years and no proration for part-time service. If you leave PG&E before the end of the year, the pay credits earned for the partial year of service are credited to your cash balance account as of December 31st or the date benefit distributions begin, whichever is earlier.

Covered Pay

Covered Pay includes:

- Straight time pay or salary for hours worked and for temporary upgrades;
- Shift, Sunday, and nuclear premiums at the straight-time rate;
- Vacation and paid time off (PTO) including amounts paid out at termination or retirement;
- Paid Sick Pay, including amounts paid out at termination or retirement due to a disability;
- Holiday pay;
- Inclement weather pay;
- Differential Pay for military training (unless such training qualifies for military leave of absence coverage);
- Pay during an approved leave of absence; and
- Pay for other time off with permission.

Special Covered Pay Provisions

Special provisions apply when you are not receiving covered pay as defined above:

- Unpaid Leave of Absence. If you are a full-time employee immediately before an authorized leave of absence begins, covered pay will equal the rate of pay of your base classification in effect immediately before your leave of absence begins. Eligible leaves of absence include, but are not limited to, personal, medical, and military leaves. Please see the *Time Off and Leaves* section of the Handbook for more information. If you are in a part time position immediately before the leave of absence begins, your covered pay is based solely on eligible earnings paid to you while actively employed; you are not eligible for pay credits while on an unpaid leave of absence.
- Long Term Disability. While you are receiving Long Term Disability Plan payments, your covered pay will be based on the greater of: (1) rate of pay of your base classification in effect on your last day worked, or (2) the amount being received under the Long Term Disability Plan.
- Workers Compensation. If you are receiving Workers' Compensation Temporary Compensation, your covered pay will equal the rate of pay of your base classification in effect immediately before your temporary disability benefits begin.

Covered Pay does not include:

- Pay or premiums for more than 40 hours a week;
- Overtime pay;
- Bonuses of any kind or commissions;
- One-time payments including incentives, recognition awards, severance payments, excess vacation payments, or sale of vacation;
- Non-taxable payments including Workers' Compensation, state disability plan benefits, reimbursements or other expense allowances;

- Per diem allowances, reimbursements and other special fees or allowances; or
- Otherwise eligible covered pay while you are receiving pay credits based on a Special Covered Pay provision.

Covered Pay that may be considered by the Retirement Plan is also limited by requirements of the Internal Revenue Service. For 2014, Covered Pay up to $260,000 is considered for determining your Retirement Plan benefits. This limit is indexed for inflation and may increase for future years.

Interest Credits

In addition to pay credits, your Cash Balance Pension Account is also credited with interest. On the last day of each calendar quarter, your cash balance account is credited with interest equal to your cash balance account as of the first day of the calendar quarter multiplied by a quarterly interest rate.

The quarterly interest rate is calculated by averaging the published annual yields for 30-year Treasury Bonds for the three months immediately preceding the calendar quarter, then dividing by four to determine the quarterly equivalent of the average annual yield. For example, the quarterly interest rate for the April through June 2013 period equals an average of the monthly rates for January (3.08%), February (3.17%) and March (3.16%) of 2013 divided by four, or 0.784%. For any calendar quarter, the quarterly interest rate credit cannot be less than 0.4875%.

The published annual yields for 30-Year Treasury Bonds can be found on the IRS website under Retirement Plans. (see www.irs.gov/Retirement-Plans/Weighted-Average-Interest-Rate-Table for the published rates). The annual yield for each month is based on the column for the 30-year Treasury Securities Rate (30-yr TSR) and 30-year Constant Maturity Rate (30-yr TCM).

When you elect to begin benefit payments, you will receive a prorated quarterly interest credit for each month in the quarter before the date your cash balance benefit payments begin. For example, if you start payments on August 1, you will be credited with one-third of the quarterly interest that would normally be credited for the July – September quarter.

A Cash Balance Pension Account Example

Let's assume Sam is age 45 with 10 years of service and currently earns $90,000 a year. Annual pay increases by 3% each year, and interest credits are 3% per year (0.75% per quarter). Here's how Sam's account can grow over a five-year period.

Year	1	2	3	4	5
Beginning Balance	$0.00	$6,300.00	$12,980.13	$20,057.61	$28,533.77
Points (Age Plus Service)	55 (45 +10)	57 (46 + 11)	59 (47 + 12)	61 (48 + 13)	63 (49 + 14)
Annual Pay	$90,000	$92,700	$95,481	$98,345.43	$101,295.79
Q1 Interest Credits	$0.00	$47.25	$97.35	$150.43	$214.00
Q1 Ending Balance	$0.00	$6,347.25	$13,077.48	$20,208.04	$28,747.77
Q2 Interest Credits	$0.00	$47.60	$98.08	$151.56	$215.61
Q2 Ending Balance	$0.00	$6,394.85	$13,175.56	$20,359.60	$28,963.38
Q3 Interest Credits	$0.00	$47.96	$98.82	$152.70	$217.23

Year	1	2	3	4	5
Q3 Ending Balance	$0.00	$6,442.81	$13,274.38	$20,512.30	$29,180.61
Q4 Interest Credits	$0.00	$48.32	$99.56	$153.84	$218.85
Pay Credit Rate	7%	7%	7%	8%	8%
Pay Credit	$6,300.00	$6,489.00	$6,683.67	$7,867.63	$8,103.66
Ending Balance	$6,300.00	$12,980.13	$20,057.61	$28,533.77	$37,503.12

In this example, the value of the cash balance account after five years is **$37,503.12**.

Vesting

You are 100% vested in the value of your Cash Balance Pension at the earliest of:

- attaining age 55 while an employee of PG&E; or
- completing three or more years of service .

If you were previously participating in the Final Pay Pension formula and elected the Cash Balance Pension during the one-time choice period in 2013, you are vested in both your Cash Balance Pension benefit and your current Final Pay Pension benefit after completing a total of three years of service (or age 55, if earlier). Prior service earned while participating in the Final Pay Pension is counted toward this total.

If you terminate employment with the Company prior to age 55 and before earning three years of service, you will lose your right to receive a Cash Balance Pension benefit.

When Benefits Are Payable

Effective January 2014, you may review your Cash Balance Pension benefits online by visiting My Retirement section of the PG&E@Work for Me intranet site or https://pgepensioncenter.com. You may also request a Cash Balance Pension statement by sending an e-mail to the HR Service Center at HRBenefitsQuestions@exchange.pge.com, or by calling the HR Service Center at 415-973-4357 or toll-free at 800-788-2363.

Once you are vested, you can receive your Cash Balance Pension account at any time after your employment with PG&E ends. Keep in mind that your account will continue to receive interest credits for as long as the account remains in the Plan. However, unless you continue employment with PG&E, you must begin to receive your benefit no later than the April 1 of the year after the calendar year in which you reach age 70½. See “Minimum Distributions” on page 373 for important information that may apply to certain deferred retirements.

If you are seriously considering retirement in the near future, you must notify the HR Service Center at least 90 days before your proposed pension payment start date. Whether you are electing a lump sum payout or a monthly paid annuity benefit, you must submit a Pension Elections Form and supporting documentation to the HR Service Center in order to receive your pension benefit. Your single lump sum payout will be paid to you on the first of the month following your retirement date in order to allow for final processing and calculation of your Cash Balance Pension benefit. If you are receiving an annuity, your first pension payment will be paid the first of the month following your pension start date and will include both the first and the second month benefit payments.

Estimates of your lump sum payout or your pension annuity — whether performed by you online or obtained through 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.

When Your Employment Ends

If you terminate employment with PG&E and are vested in your Cash Balance Pension benefit, you'll be eligible to receive the full balance from your cash balance account in a lump sum or an actuarially equivalent monthly benefit.

If you terminate employment at age 55 or older, your retirement status will be associated with the last classification you held before your employment ends and benefit payments begin. For example, if you had union-represented service, transferred to a management position and subsequently retired, you would be considered a management retiree.

Mandatory Distributions

If you have a vested benefit from the Retirement Plan and the value of your Cash Balance Pension account (plus the present value of any benefits payable to you under the Final Pay Pension formula) is less than $5,000 as of the date you terminate employment with the Company, 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.

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 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 remain employed with the Company past age 70½, you will not be subject to minimum distributions until your actual retirement date (subject to changes in tax law).

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

Death Benefits

If you die before your cash balance account is distributed, it will be paid to your beneficiary. If you are married, your spouse is your default beneficiary. If you are not married, and you do not designate a beneficiary, your account is forfeited. For more information, see "If You Die Before You Retire" on page 377.

Payment Options

You can receive your vested cash balance account in a one-time lump sum payout or as a monthly paid annuity payable for your lifetime at any time beginning the first of the month after your employment ends.

Note to participants with benefits earned before January 1, 2013: You must make a separate payment election for your Final Pay Pension benefit. You may elect to receive your cash balance account in the same annuity form and at the same time as your Final Pay Pension benefit. There may be situations, however, where your cash balance account can be distributed, but you must wait until a later date to receive your Final Pay Pension benefit.

Lump-Sum Payout

You may elect to receive a one-time distribution of your entire Cash Balance Pension account at retirement or termination of employment. The lump-sum payment is equal to the balance of your cash balance account after final pay and interest credits. There is no reduction for early retirement. The distribution is taxable and early withdrawal tax penalties may apply if you take a distribution before retirement age. If you roll over your account directly to an IRA or another qualified retirement plan, you will be taxed only when you actually receive the money.

If you are married and your benefit under the Retirement Plan is greater than $5,000, and you elect a lump sum payout, your spouse must consent to this election in writing. Both you and your spouse must sign the Pension Elections Form, and your signatures must be witnessed by a Notary Public.

If your account balance is $5,000 or less, it will automatically be paid to you as a lump-sum payout. See "Mandatory Distributions" on page 373 for more information.

Normal Annuity Payments

If your account balance is $5,000 or more, and you do not elect a lump-sum payout at termination of employment, the normal form of payment for your cash balance pension is a monthly paid annuity.

The monthly paid annuity is the actuarial equivalent of your Cash Balance Pension account. An actuarial equivalent is the fixed monthly benefit payable for your lifetime that is the equivalent value to your cash balance account. This actuarial equivalent is determined by multiplying your account balance dollar value by a factor based on your age (or the ages of you and your spouse/beneficiary), and interest and mortality rates set by the IRS in August of the prior year. For example, an annuity starting in February 2014 will use factors based on the IRS mortality and interest rates set in August 2013.

Below are the normal forms of payment based on your marital status at the time your benefit is scheduled to begin:

- **If you are unmarried 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.
- **If you are married at the time you begin receiving payments** from the Retirement Plan, you will automatically receive a 50% joint pension with your spouse as the joint annuitant (a "Marital Pension"). This form of benefit will, upon your death, continue making benefit payments to your spouse for your spouse's lifetime based on 50% of the payment amount during your life. If you elect continued payments of less than 50% for your spouse, or you elect a joint pension with someone other than your spouse, both you and your spouse must sign the Pension Elections Form, and your signatures must be witnessed by a Notary Public.

For purposes of the Retirement Plan, you have a "spouse" if you are legally married under applicable law of a state or foreign jurisdiction, including a same-sex couple. However, in accordance with IRS guidance, a registered domestic partnership, civil union, or other similar formal relationship that is not denominated as a marriage under the law is not treated as legally married for purposes of the Plan.

Optional Forms of Annuity Payments

If you wish, you may waive the normal form of annuity payment and receive your benefit in one of the following optional forms of annuity payments.

Single Life Pension

- This is the normal annuity form for unmarried participants. If you are married, you may elect to receive your pension based on your own life expectancy only and not provide any payments to a survivor. 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 signatures must be witnessed by a Notary Public.
- If you elect to receive your Cash Balance Pension benefit in the form of a Single Life Pension benefit payments will stop at your death. A continuing Cash Balance pension will not be paid to your spouse or any other person after your death.

Joint Pension

These options are similar to the normal annuity form for married participants. 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% 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.

You may elect a joint pension that provides for a payment of 25%, 50%, 75%, or 100% of your reduced benefit to your joint pensioner after your death. If you are married, your spouse will need to consent to your election of a joint pension with someone other than your spouse, or a joint pension with your spouse that only pays 25% of your benefit after your death.

In certain cases, IRS rules may limit the joint pension benefit payable to a non-spouse joint pensioner. The Plan Administrator will notify you if your desired joint pension election is affected by these rules.

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.

You may elect a Special Joint Pension that provides for a payment of 25%, 50%, 75%, or 100% of your reduced benefit to your joint pensioner after your death. If you are married, your spouse will need to consent to your election of a joint pension with someone other than your spouse, or a Special Joint Pension with your spouse that only pays 25% or 50% of your benefit after your death. To make this election, both you and your spouse must sign the Pension Elections Form, and your signatures must be witnessed by a Notary Public.

Making Your Payment Election

Your elections are made on your Pension Elections Form. To help you make the best decision for your needs, the HR Service Center and Xerox HR Services will provide you with an estimate of the pension amounts you would receive under the various payment options available from the 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 in time to process the payment (at least 30 days before your requested retirement date), your pension benefit will be recalculated to start the first of the next month following the end of the 30-day period. For example, if your requested pension benefit date is May 1, 2014, and your completed paperwork is received on April 10, 2014, your new pension benefit date will be recalculated for June 1, 2014. The Retirement Plan does not allow retroactive payments.

Changing Your Election

Once you elect a payment option, you may change your election 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 your pension date.

Once your pension date has passed, all of your elections are irrevocable. For instance, if you are receiving a pension benefit that continues a benefit to your spouse, 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, even if you remarry.

Different rules apply if you elect a joint pension and either you or your joint pensioner dies before your 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 unless you elect otherwise. If you die before your payments begin, your surviving spouse or named beneficiary will receive the larger of the pre-retirement survivor pension (see "If You Die Before You Retire" on page 377 or your elected joint pension.

Loss or Reduction of Benefits

There are certain circumstances under which your Cash Balance Pension 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 three years of service, you will lose your right to receive a Cash Balance Pension benefit.
- If you elect to receive your Cash Balance Pension benefit in the form of a Lump Sum Payment, no further payments will be made to your spouse or any other person after the full value of our account balance has been paid to you.
- If you elect to receive your Cash Balance Pension benefit in the form of a Single Life Pension, Cash Balance Pension benefit payments will stop at your death. A continuing pension will not be paid to your spouse or any other person after your death.
- If you are not married and you die without a designated beneficiary, your Cash Balance Pension account will be forfeited.

Facility of Payment

If you are entitled to any payment under the Plan, and the Plan Administrator determines that you are physically or mentally incompetent and no guardian or conservator has been appointed to receive your payment, the Plan Administrator may make payments on your behalf to a third-party to be applied for and on behalf of and for your benefit. Payments made on your behalf will completely discharge the Plan's responsibility for the amount of the payment.

No Guarantee of Employment

Participation in the Plan does not guarantee your right to employment with PG&E or any affiliates. Further, nothing set forth in this Summary Plan Description should be interpreted to give you or your beneficiary any legal or equitable rights against PG&E or its affiliates.

Military Service

Federal law provides rights to certain reemployed veterans for service credit, including for purposes of benefit accruals in certain situations, for periods of military service. Please contact the HR Service Center for more information.

Your Responsibility to Maintain a Current Address

You will receive periodic information regarding your Retirement Plan benefits. After your employment ends, you will receive periodic information about your vested benefit under the Retirement Plan. It is your responsibility to notify the Plan Administrator of any changes in your home address. To change your address, contact the HR Service Center at 415-973-4357 or toll-free at 800-788-2363.

If correspondence regarding your plan benefits is returned as undeliverable, the Plan Administrator will make efforts to locate you, including engaging the services of third-party address search services. If the Plan Administrator is unable to locate you on the latest date upon which your Cash Balance Pension payments must start, your benefit under the Plan will forfeited and used to offset future employer contributions. If a proper claim is later presented to the Plan Administrator, your benefit will be reinstated without any earnings or interest adjustment.

Borrowing, Pledging, and Assigning Interests in the Plan

No participant or beneficiary may borrow against, pledge, or assign — voluntarily or involuntarily, or by operation of law — any interest in the Retirement Plan or in any distribution to be made under the Retirement Plan.

However, this does not prevent a spouse, former spouse, child, or other dependent of an employee to claim an interest in an employee's Retirement Plan benefits under a QDRO issued by a court (see "If You Get Divorced" on page 377). Generally, except as described above, no party, including creditors of the PG&E, has or may create a lien on your benefit under the Retirement Plan.

What Happens…

If You Leave the Company

As long as you are fully vested in your benefit under the Plan, you can elect to receive the full balance of your cash balance account paid to you in a single lump sum payment, or to receive an actuarially equivalent monthly lifetime benefit. A lump sum payment or the monthly benefit amount would be subject to income tax. Any withdrawals before age 59½ could incur federal or state early withdrawal tax penalties unless you roll your account balance to an IRA or another qualified retirement plan.

If You Get Divorced

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, or a free sample QDRO and QDRO procedures, you can call the HR Service Center at 415-973-4357 or 800-788-2363.

If you are ready to retire or begin your pension and your divorce is final 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 QDRO 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.

If you have both a Final Pay Pension and a Cash Balance Pension, and you have an existing QDRO relating to your Final Pay Pension, you and your ex-spouse may provide a revised QDRO that addresses both benefits. If you choose not to do that, the existing QDRO will apply to both of your benefits – your frozen Final Pay Pension and your Cash Balance pension – as interpreted by the Plan Administrator or its delegate.

If You Die Before You Retire

The Retirement Plan may provide a pension benefit for your spouse or a designated beneficiary if your death occurs before you receive your cash balance account. If you are married, your spouse is automatically your designated beneficiary. You must complete a Pre-Retirement Beneficiary Designation Form if you are not married, or wish to name a beneficiary other than a spouse for your Retirement Plan. If you are married, your spouse must consent to your naming someone else, and your spouse's consent must be witnessed by a Notary Public. Contact the HR Service Center for more information and the necessary forms. For purposes of the Retirement Plan, you have a "spouse" if you are married under applicable law of a state or foreign jurisdiction, including a same-sex couple. However, in accordance with IRS guidance, a registered domestic partnership, civil union, or other similar formal relationship that is not denominated as a marriage under the law is not treated as legally married for purposes of the Plan.

You will receive a notice that describes your right to designate a pre-retirement beneficiary. If you're married, that notice describes your right to designate a non-spouse beneficiary to receive a pre-retirement survivor's pension — and your spouse's right to consent to such election. Contact the HR Service Center or visit PG&E@Work for Me/ My Retirement or https://pgepensioncenter.com for more information and the necessary Pre-Retirement Beneficiary Designation Forms.

If you are married:

- Your spouse is your designated beneficiary. If you die before receiving your benefits, your spouse will receive your vested cash balance account in a single life pension annuity. Instead of the single life annuity, your surviving spouse may elect to receive the amount of your vested account in a single lump-sum payment.
- If you have named someone other than your spouse as beneficiary, your beneficiary will receive your vested cash balance account in a single lump-sum payment. Instead of the lump sum, your beneficiary may elect to receive the amount of your vested cash balance account in a single life pension annuity.

If you are not married:

- You must designate a beneficiary to have your cash balance account paid as a survivor benefit. If you are not married and do not designate a beneficiary, your cash balance account will be forfeited upon your death.
- If you die before commencing your benefit, your beneficiary will receive your vested cash balance account in a single lump-sum payment. Instead of receiving the lump sum, your beneficiary may elect to receive the amount of your vested cash balance account in a single life pension annuity.

If the total Retirement Plan benefit payable on your death is less than $5,000 as of the date of death, the mandatory distribution rules will apply to benefits payable to the spouse or beneficiary. See "Mandatory Distributions" on page 373 for more information.

Payment of the survivor benefit will be made as of the first of the month following your death. Your spouse or beneficiary may elect to defer payment until a later date unless your account is subject to mandatory distribution. A beneficiary election to receive payment in the form of a pension annuity must be made no later than December 31 of the year following your death.

If you die *after* beginning monthly payments of your benefit, payments will continue to your spouse or designated beneficiary only if you elected an annuity form of payment that includes a survivor benefit.

Note to participants employed before January 1, 2013: If you are vested, and die before receiving a monthly benefit under the Final Pay Pension formula, your spouse or designated beneficiary may be eligible to receive a monthly survivor benefit from that benefit formula. See "If You Die Before You Retire" in the *Retirement Plan — Final Pay Pension Benefit* section for more details about the pre-retirement survivor annuity under the Final Pay Pension formula. You may elect a different beneficiary for your Cash Balance Pension than the person you choose for your Final Pay Pension benefit.

If You Die Within 30 Days of Your Retirement Date

If your death occurs within 30 days of your retirement date, special rules apply:

- If you are married and 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 Pre-Retirement Survivor's Pension described above.
- If you are not married and have elected a joint pension with someone who is not on your Pre-Retirement Beneficiary Designation Form, or if you are married and have elected a joint pension with someone other than your spouse, your joint pensioner will receive the greater of the joint pension that you elected or the amount of the Pre-Retirement Survivor's Pension.
- If you are single and you have elected a joint pension with your pre-retirement beneficiary, your beneficiary will receive the greater of the joint pension you have elected or the Pre-Retirement Survivor's Pension.

If You Are Rehired on or After January 1, 2013

If you leave PG&E while participating in the cash balance formula and are later re-hired, the impact on your cash balance account will depend on your vesting status and on whether you received a Cash Balance Pension benefit upon leaving PG&E:

If You Were Vested in Your Cash Balance Pension at Termination	
And You Received Your Cash Balance Pension Benefit	▪ **Previous Lump-Sum Payout:** If you received a lump-sum payout of your cash balance account, when you are rehired, your starting cash balance account at rehire will equal $0. Going forward, you'll receive pay credits and interest credits to your account. Prior service will be considered in determining points used to calculate pay credits. ▪ **Previous Monthly Annuity Payments:** If you are receiving monthly annuity payments from your previous cash balance account, these payments will continue. A new cash balance account will be established for you with an initial balance of $0. Going forward, you'll receive pay credits and interest credits to your account. Prior service will be considered in determining points used to calculate pay credits.
And You Did Not Receive a Cash Balance Pension Benefit	▪ If you didn't receive a distribution from your previous cash balance account, then when you are rehired, your account balance will equal the balance at your termination date plus interest credits earned until your date of rehire. Going forward, you'll receive pay credits and interest credits to your account. Prior service will be considered in determining points used to calculate pay credits.

If You Were Not Vested in Your Cash Balance Pension at Termination	
And Your Break-in-Service Was…	▪ **Less Than Five Years Prior to Rehire:** If you have a break-in-service that is less than five years, then when you are rehired, your account balance as of your termination date will be restored and interest credits for the period of the break will be applied. Going forward, you'll receive pay credits and interest credits to your account. Prior service will be considered in determining points used to calculate pay credits. ▪ **Five Years or More Prior to Rehire**: If your break-in-service equals or exceeds five years, then when you are rehired, your cash balance account will equal $0. Going forward, you'll receive pay credits and interest credits to your account. Prior service will be considered in determining points used to calculate pay credits.

If You Were Vested in a Final Pay Pension at Termination	
And You Started Receiving Your Final Pay Pension Benefit	▪ **The annuity you are receiving will continue being paid during re-employment; there is no suspension of benefit.** You will start earning a new Cash Balance Pension benefit upon re-employment. However, points used to determine cash balance pay credits will recognize prior service for which a Final Pay Pension is being paid.
And You Have Not Started Receiving Your Final Pay Pension Benefit	▪ You will automatically begin earning a Cash Balance Pension. Points used to determine pay credits will recognize prior service. You can elect to start receiving your vested Final Pay Pension benefit payments at any time after your employment ends and you are age 55 or older.

If You Were Not Vested in a Final Pay Pension at Termination	
And Your Break in Service Was:	▪ **Less than Five Years:** Your benefit earned under the Final Pay Pension up to your termination date will be restored. Prior service will be recognized for cash balance pay credits and vesting in both the Final Pay Pension and Cash Balance Pension benefit. ▪ **More than Five Years:** Your benefit earned under the Final Pay Pension up to your termination date will not be restored. However, your prior service will be recognized for determining cash balance pay credits going forward.

If You Also Have a Benefit Under the Final Pay Pension Formula

Two types of employee may also have a benefit under the Final Pay Pension — an employee who elects the Cash Balance Pension during the one-time pension choice period in 2013, and an employee who terminated while participating in the Final Pay Pension and is re-hired in 2013 or later.

If you elect the Cash Balance Pension during the one-time pension choice period in 2013, your Retirement Plan benefits will have two components:

- Your accrued **Final Pay Pension benefit** as of December 31, 2013 payable as a monthly annuity; plus
- Your accrued **Cash Balance Pension benefit** from January 1, 2014, through the end of your PG&E employment (which can be paid to you as a lump sum or as an actuarially equivalent annuity).
- If you are a rehired employee and earned a Final Pay Pension during your past employment, your Retirement Plan benefits will have two components:
  - Your accrued **Final Pay Pension benefit** earned as of your last day of employment before your first rehire date on or after January 1, 2013 (payable as a monthly annuity); plus
  - Your accrued **Cash Balance Pension benefit** from your date of re-hire, through the end of your PG&E employment (which can be paid to you as a lump sum or as an actuarially equivalent annuity).

All service earned under the Final Pay Pension will be recognized in determining pay credits under the Cash Balance Pension. For details about your Final Pay Pension, see the *Retirement Plan —Final Pay Pension* section of this Handbook.

If you are earning a benefit under the Cash Balance Pension formula, you are also eligible for a higher Company match to your 401(k) contributions. See the Retirement Savings Plan description for more information.

If Your Benefit Is Affected by IRS Limits

The Internal Revenue Code (IRC) and ERISA impose limitations on benefits provided under the Retirement Plan, both alone and in conjunction with other plans sponsored by PG&E. Generally, these limitations affect only the benefits of certain highly compensated employees. The Plan Administrator will notify you if you are affected by these limits.

If the Retirement Plan becomes less than 80% funded, as determined under applicable IRC rules, the Retirement Plan's ability to pay lump sum benefits may be restricted. In addition, if the Retirement Plan becomes less than 60% funded, additional payment restrictions may apply and, subject to applicable IRC requirements, all Retirement Plan participants will automatically cease to earn any additional Retirement Plan benefits. The Plan Administrator will notify you if you are affected by these restrictions.

If You Take a Leave of Absence or Go on LTD

If you are on disability leave or take an approved unpaid leave of absence (including leave while receiving Workers' Compensation temporary disability payments):

- You'll continue to receive interest credits during your leave.
- If you're a full-time employee immediately prior to the authorized leave of absence, pay credits that would have been earned during the leave period will be granted based on your straight-time rate of pay in effect for your classification immediately before your leave began.
- If you're a part-time employee, no pay credits are earned during the unpaid leave.

If you are receiving Long Term Disability (LTD) benefits, you will receive pay credits that would have been earned during the LTD period based on the greater of your:

- last active straight-time rate of pay in effect for your classification; or
- LTD benefit.

You are not eligible to take a lump-sum payout or begin receiving an annuity while you are on a leave of absence or LTD. If you have a severance from service and elect to start Retirement Plan benefits, and are later reinstated on to LTD, your pension annuity (if elected) will continue, but your LTD benefit will be reduced by the full pension benefit. If you elect a single lump-sum payout of your Cash Balance Pension, the offset to your LTD benefit will equal the actuarial equivalent value of your cash balance account at the time your lump-sum payment was made.

Claims and Appeals

Requesting Benefit Payments

To receive a benefit from the Retirement Plan, you generally must complete a Pension Elections Form and provide any additional information needed to process your request and withhold taxes. If you disagree with the response to your request for benefits, whether in whole or in part, and believe you may be entitled to benefits greater than the amount determined by the Plan Administrator, you have the right to pursue your claim for benefits through the Retirement Plan's Claims Procedures. You also have the right to file suit in a Federal court once you have exhausted all steps of the Retirement Plan's Claims Procedures.

Formal Benefit Claims Procedures

To make a formal claim for benefits, you must submit your claim within at least 60 days after you first receive the information on which your claim is based 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 claim for benefits; 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, and after exhausting your administrative remedies under the Plan.

If you are not satisfied with the Benefit Department's decision, you may then submit a written appeal for review (within 90 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.

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 instead of the appeals procedures described above.

The administrative remedies described in this section (as well as a grievance or adjustment procedure of the appropriate collective bargaining agreement if it is used instead of the appeal rights described above) must be exhausted before any legal action can be taken by a claimant. If a claimant timely exhausts all levels of appeal available to the claimant under the Plan's claims procedures (including appeals to both the Plan Administrator and the EBAC), any permissible legal action under ERISA section 502(a) must be initiated within the applicable statute of limitations. The review procedures described in this section are the exclusive administrative procedures provided under the Plan.

The Pension Benefit Guaranty Corporation

Your pension benefits under the Retirement Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under a terminated plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- normal and early retirement benefits;
- disability benefits if you become disabled before the pension plan terminates; and
- certain benefits for your survivors.

The PBGC generally does not cover:

- benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates;
- some or all of the benefit increases and new benefits based on plan provisions that have been in place for fewer than five years at the time the plan terminates;
- benefits that are not vested because you have not worked long enough for the company;
- benefits for which you have not met all of the requirements at the time the plan terminates;
- certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and
- non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money you plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington DC 20005-4026 or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at http://www.pbgc.gov.

Or contact:

Pacific Gas and Electric Company
Benefits Department
1850 Gateway Boulevard, 7th Floor
Concord, CA 94520
415-973-4357 or 800-788-2363

Tax Considerations

All Plan distributions are considered taxable income and are subject to normal federal and (if applicable) state and/or local income taxes.

Annuity payments are subject to income tax withholding at ordinary income tax rates.

If you elect a lump-sum payment to be paid to you, the Company must withhold 20% federal tax from your distribution unless you elect a direct rollover. This withholding is sent to the IRS and is credited as part of your tax withholding for the year in which you receive your distribution.

If you're under age 59½ and don't roll over your lump-sum payment to an Individual Retirement Account (IRA) or other tax-qualified retirement plan, your distribution may be subject to a 10% federal income tax penalty in addition to the 20% withholding tax. State income tax penalties may also apply. However, the additional 10% IRS penalty does not apply if your payment is:

- paid to you because you leave the Company during or after the year in which you reach age 55;
- paid to you after you're permanently and totally disabled;
- paid to you as equal (or almost equal) payments over your life expectancy (or you and your beneficiary's combined life expectancies);
- used to pay certain medical expenses; or
- paid to your beneficiary after your death.

Tax laws are complicated and subject to frequent change. You should consult a qualified tax advisor before making your distribution election.

Retirement Savings Plan

The PG&E Corporation Retirement Savings Plan for Union-Represented Employees ("the Plan") offers you a valuable way to save for your future, through pre-tax and after-tax contributions, as well as employer contributions.

The Plan is a restatement of the Pacific Gas and Electric Company Savings Fund Plan for Union-Represented Employees which offers eligible employees of PG&E Corporation, Pacific Gas and Electric Company and other designated subsidiaries a tax-advantaged way to save for retirement. The Plan also includes an additional component — an Employee Stock Ownership Plan (ESOP), which is linked to the PG&E Corporation Stock Fund investment option (see "PG&E Corporation Stock Fund Information" on page 400 for more information. The Plan is intended to qualify under section 401(a) and section 401(k) of the Internal Revenue Code (IRC). The Plan is also intended to satisfy the requirements of section 404(c) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), including all applicable regulations issued by the United States Department of Labor and the United States Treasury Department.

"Company" Defined

Throughout this Retirement Savings Plan section, unless otherwise stated, reference to "Company" or "PG&E" means PG&E Corporation. The Plan and benefits described in the section also apply to employees of Pacific Gas and Electric Company and other designated subsidiaries, but only to the extent that such entities are participating employers with respect to the described plans or programs and such employees meet the eligibility requirements of the plans or programs.

This Summary Plan Description contains a summary of your rights and benefits under the Plan. It is not meant to interpret, extend or change the Plan in any way. A copy of the Plan is on file with the Administrator and may be reviewed by any participant or beneficiary at any reasonable time.

The Plan document governs in the event of any discrepancy between this Summary Plan Description and the actual provisions of the Plan document. PG&E Corporation reserves the right to change, amend, or terminate the Plan at any time.

This Retirement Savings Plan section constitutes part of a prospectus covering securities that have been registered under the Securities Act of 1933. **This prospectus is attached at the end of this Summary of Benefits Handbook.**

If you have questions about the Plan or the Summary Plan Description, please contact the RSP Service Center at 877-PGE-401k or 877-743-4015 or the Plan Administrator (see the *Rules, Regulations and Administrative Information* section for contact information).

In This Section

Retirement Savings Plan at a Glance

- The Retirement Savings Plan for Union-Represented Employees, sometimes referred to as the 401(k) plan, offers a tax-advantaged way for you to save for retirement. You may contribute a portion of your salary to the Plan on a pre-tax basis, an after-tax basis, or a combination of both.
- Beginning January 1, 2013, certain aspects of participation in the Plan will depend on the form of pension benefit that you earning under the Pacific Gas and Electric Company Retirement Plan (the Retirement Plan), or your date of hire or rehire. If you are participating in the Cash Balance Pension, or generally were hired or rehired after 2012 into an eligible position, you will be automatically enrolled in the Plan when you have completed one year of service, and you will be eligible for a higher employer match. Please see the *Retirement Plan — Cash Balance Pension Benefit* section for more information about your pension benefits.
- After an eligible employee has completed one year of service and makes contributions to the Plan, certain participant contributions are eligible for matching employer contributions. These matching employer contributions are invested in units of the PG&E Corporation Stock Fund, but you may transfer company matching contributions to other Plan investment options at any time.
- You are fully vested in your contributions to the Plan and in all employer contributions credited to your account, together with any earnings.
- Contributions made on a pre-tax basis are made before income taxes are withheld, reducing your taxable income. Income taxes on pre-tax contributions and any earnings are deferred (postponed) until you withdraw the money from the Plan. Although after-tax contributions are deducted after income taxes are withheld, taxes on earnings are deferred so long as the amounts remain in the Plan. The Plan does not offer a Roth 401(k).
- The Plan offers three tiers of investment options for you to choose from. Your individual investment strategy should reflect your personal savings goals and tolerance for financial risk. Ultimately, your investment choice is an individual decision.
- If you need professional advice on how to invest contributions to the Plan, you should seek assistance from a financial consultant or tax advisor. You may also obtain investment advisory assistance through the services provided by Financial Engines (see “Investment and Advisory Services” on page 394 for more information).

Participating in the Plan

Who’s Eligible

In general, the Plan covers those union-represented employees of participating employers within PG&E Corporation whose collective bargaining agreement provides for participation in the Plan. Certain classifications of union-represented employees, such as Hiring Hall, Temporary Additional, and Outage classifications are not eligible to participate in the Plan.

You may participate in the Plan for as long as you remain an eligible employee of a participating employer within PG&E Corporation.

If you are rehired by a participating employer within PG&E Corporation, and you had previously worked more than 12 months for PG&E or you had left PG&E less than 12 months before your rehire date, you will receive credit for your past service.

Enrolling in the Plan

You are eligible to participate in the Plan when you start work in an eligible job classification. You may enroll and elect to have pre-tax, after-tax, or a combination of both types of contributions in an amount up to 20% of your covered compensation deducted from your pay.

Your elected contributions to the Plan will be deducted from your salary as soon as practicable after you enroll, or, if applicable, once you are automatically enrolled in the plan (see "Automatic Enrollment in the Plan," below).

After your personal employment data is processed, you will receive an enrollment kit from the Plan's service provider, Fidelity Investments (Fidelity). You can enroll through Fidelity NetBenefits℠ online account services at www.401k.com. You may also enroll using Fidelity's RSP Service Center (877-PGE-401K or 877-743-4015.) You may choose the percentage of your covered compensation, from 0% up to 20% that you wish to contribute to the Plan and your investment elections. If you don't provide investment instructions for your Plan contributions, including if you are automatically enrolled in the Plan, they will be invested in the Target Date Fund with a target date closest to your 65th birthday until you specify otherwise (see "Investment Options" on page 394).

Automatic Enrollment in the Plan

You will be automatically enrolled in the Plan if you are an:

- Eligible employee hired or rehired on or after January 1, 2013, or
- Eligible employee hired or rehired before January 1, 2013 who elects to participate in the Cash Balance Pension formula of the Pacific Gas and Electric Retirement Plan ("Retirement Plan"), effective as of January 1, 2014.

All other groups of employees, including eligible employees who continue to participate in the Final Pay pension formulas in the Retirement Plan are not covered by automatic enrollment and must complete the enrollment process to begin making contributions to the Plan (see "Enrolling in the Plan," above).

If automatic enrollment applies to you, it will work as follows:

If you are hired or re-hired on or after January 1, 2013: You are automatically enrolled for pre-tax deductions at a rate of 8% of your covered compensation. Your automatic enrollment will be effective at the beginning of the first pay period that starts one year after your hire date (once you become eligible to receive matching contributions), or as soon thereafter as practicable, unless you specifically elect not to participate in the Plan, or elect to contribute a different rate of your covered compensation.

After your personal employment data is processed, you will receive an enrollment kit from the Plan's service provider, Fidelity Investments (Fidelity). Your enrollment kit will indicate your automatic enrollment date, pre-tax contribution percentage, and the default investments that will apply. This kit will also tell you how to change the percent of pay you are contributing, make your personal investment elections, and how to decline to participate in the Plan. If you enroll on your own before your automatic enrollment effective date, there will be no change to your contribution or investment elections.

If you elected to participate in the Cash Balance Pension during the one time pension choice period in 2013: The automatic enrollment process applies to you beginning January 1, 2014. If you are contributing less than 8% of your covered compensation as of January 1, 2014, you will be automatically enrolled for pre-tax deductions at the 8% contribution level as of the first payroll period, or as soon thereafter as practicable, unless you specifically elect not to participate in the Plan or elect a different contribution rate.

Re-enrollment of Automatically Enrolled Participants: If automatic enrollment applies to you, and you reduce your contribution percentage below 8% of covered compensation, you will be automatically enrolled at the 8% contribution level in January of the next plan year. Each time you are re-enrolled, you may elect not to participate in the Plan, or elect to contribute a different rate of your covered compensation.

If this is the first time you are automatically enrolled in the Plan: You may request a refund of your automatic enrollment contributions no later than 90 days after the date that the first automatic enrollment contribution is made. You will receive a distribution of the amounts deducted from your pay under this automatic enrollment provision. The distribution will be increased to reflect earnings on your contributions, or decreased to reflect investment losses, but you will forfeit any company matching contribution and applicable earnings on such company match. Your request to receive a refund will also be considered an election to defer 0% of your covered compensation until you elect to begin making contributions or automatic re-enrollment.

Contribution refunds are subject to income tax when distributed, but early distribution penalty taxes do not apply. These amounts are not eligible for a tax-deferred rollover.

By law, you may only request a refund the first time the automatic enrollment process under this Plan is applied to you. This is true whether or not you elected a refund when you were automatically enrolled for the first time, or if you are a rehire who was automatically enrolled in the Plan during a period of previous employment.

Beneficiary Designation

Once you are participating in the Plan, you should designate a beneficiary. This may be done online at Fidelity NetBenefits℠ or www.401k.com. If you do not have online access, you may contact Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015) to request a beneficiary designation form.

If you do not designate a beneficiary, your default beneficiary will be your spouse if you are married, or your estate if you are not married. If you are married and designate anyone other than your spouse as a beneficiary, you must submit notarized evidence of spousal consent. You should review your beneficiary designations regularly, and any time your circumstances change (such as marriage, divorce, or birth or adoption of a child). You may change your beneficiary designation at any time.

For purposes of the Plan, you have a "spouse" if you are legally married under applicable law of a state or foreign jurisdiction, including a same-sex couple. However, in accordance with IRS guidance, a registered domestic partnership, civil union, or other similar formal relationship that is not denominated as a marriage under the law is not treated as legally married for purposes of the Plan.

Contributions

This section contains information about the types of contributions you may make to your account. To start, stop, or change the amount of your contributions to the Plan, you can log on to Fidelity NetBenefits℠ online account services at www.401k.com or call Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015) and speak with a Participant Services Representative or use the automated voice response system.

PG&E makes every effort to send your contributions and the company matching contribution to Fidelity within several business days, or as soon as practicable after your payroll date. When Fidelity receives the funds, they invest your contributions based on the investment options you selected.

Vesting

You are 100% vested at all times in the contributions you make to your own account. You are also 100% vested at all times in employer contributions credited to your account.

Employee Contribution

You may elect to contribute any amount in 1% increments from 1% to 20% of your covered compensation on a pre-tax basis, on an after-tax basis, or a combination of both.

Covered compensation includes:

- straight-time pay for hours worked and for temporary upgrades;
- shift and nuclear premiums at the straight-time rate;
- vacation pay (including vacation upon termination or retirement), sick leave pay, holiday pay, and pay during an approved leave of absence;
- inclement weather pay;
- differential pay for military service;
- pay for other time off with permission; or
- employer-paid benefits for disability, including and supplemental benefits for industrial injury.

Covered compensation does not include:

- pay or shift and nuclear premiums for more than 40 hours a week;
- overtime;
- one-time payments including bonus and incentive pay and recognition awards;

- reimbursements
- severance payments, or any lump sum payments;
- per diem allowances and other special fees or allowances; or
- payments from any other benefit plan provided through insurance or that are not considered to be taxable wages paid by an employer, including insured short-term disability and long-term disability benefits, workers' compensation and state disability.

You may start, stop, or change the amount of your pre-tax, after-tax, or catch-up contributions to the Plan at any time. You can do so by logging on to Fidelity NetBenefits℠ online account services at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015) and speaking with a Participant Services Representative or using the automated voice response system.

Employee contributions may be directed to any one or more of the investment fund options available under the Plan (see "Investment Options" on page 394).

Contribution investment elections must be made in 1% increments to any fund or combination of funds and must equal 100% of your elected contribution amount. Changes to contribution amounts are subject to payroll deadlines, but are generally effective within 30 days of receipt of your elections.

Catch-Up Contribution

Participants who will be age 50 or older before the close of the plan year (December 31) are eligible to make catch-up contributions to the Plan in that plan year or thereafter. Catch-up contributions are in addition to your regular Plan contributions. If eligible, you may elect a catch-up contribution from 1% to 20% of your covered compensation on a pre-tax basis up to the maximum dollar amount allowed by law (which amount is periodically adjusted by the Treasury Department). The maximum catch-up contribution is $5,500 for 2014.

In order for the amounts you elect to be eligible as catch-up contributions, you must reach one of the following limits (see "Contribution Limits" on page 393):

- IRC annual pre-tax section 401(k) contribution limit ($17,500 for 2014); or
- IRS annual additions limit including your pre-tax, after-tax and employer contributions combined ($52,000 for 2014); or
- Plan contribution percentage limit of 20% of covered compensation.

If you do not reach one of these limits, your catch-up contributions will be considered regular plan contributions. Catch-up contributions are not eligible for matching employer contributions.

Your catch-up contributions will be treated as pre-tax contributions, but are not counted towards the IRC section 401(k) limit or annual additions limit.

Matching Employer Contribution

Matching employer contributions are made on behalf of eligible employees who contribute to the Plan and are a way in which PG&E shares in providing retirement savings for you. Matching contributions are made each payroll period.

You become eligible for matching employer contributions when you have completed 12 months of service and you make contributions to the Plan. The amount of matching employer contributions that you are eligible to receive is determined based on the type of pension you are earning under the Retirement Plan (see the *Final Pay* section and the *Cash Balance* section in the introduction to the *Retirement Benefits* section for more information on the pension formulas.)

If you are earning a Final Pay Pension under the Retirement Plan, matching employer contributions will be made in the following percentages according to your years of service

Length of Service	Matching Employer Contribution
1 to 3 years of service	60% of the employee's pre-tax and/or after-tax contributions that do not exceed 3% of the employee's covered compensation.
3 years of service or more	60% of the employee's pre-tax and/or after-tax contributions that do not exceed 6% of the employee's covered compensation

A "year of service" is the completion of 12 months of employment within PG&E. If you have terminated employment and are rehired, your past service may be considered when determining your years of service. If you had previously worked more than 12 months before your employment ended, or you are rehired within 12 months of your termination date, you will receive credit for your past service.:

If you are earning a Cash Balance Pension under the Retirement Plan, you are eligible for a matching employer contribution of $0.75 per dollar that you contribute up to 8% of pay. If you are hired or rehired after December 31, 2012, you are eligible for this company matching contribution when you have completed one year of service. If you elected to move to the Cash Balance Pension during the one-time Pension Choice period in 2013, you are eligible for the company matching contribution of $0.75 per dollar on your contributions up to 8% of covered pay when you begin participation in the Cash Balance Pension as long as you have completed one year of service.

To receive the maximum matching employer contribution, you must contribute the maximum percentage of your pay that is eligible for the match each pay period. You must contribute at least 3% or 6% of your covered compensation (for Final Pay Pension participants) depending on length of service or 8% of your covered compensation (for Cash Balance Pension participants) to receive the maximum employer match.

You are 100% vested at all times in matching employer contributions credited to your account.

Matching employer contributions are invested in the PG&E Corporation Stock Fund. You may, however, reallocate the employer match to the other investment options at any time after it has been credited to your account, subject to the prohibition against insider trading (see "PG&E Corporation Stock Fund Information" on page 400 for more information).

For more information about your investment options for matching employer contributions, (see "Investment Options" on page 394).

Rollover Contributions from Previous Employer Plans

As long as you are eligible to make contributions to the Plan, you may rollover (either directly or within 60 days upon receipt of the distribution) a taxable or non-taxable distribution from most qualified retirement plans offered by a previous employer — including plans from tax-exempt non-profit organizations (IRC section 403(b) plans) and state and local governments (IRC section 457 plans) — or from an Individual Retirement Account (IRA). The Plan does not accept rollovers of Roth 401(k) contributions from another qualified retirement plan. The Plan reserves the right to refuse any rollover from a participant that would disqualify the Plan under the Internal Revenue Code (IRC).

You may invest rollover contributions in any of the investment options available under the Plan. Rollover contributions will be accounted for separately from any other contributions. Rollover contributions and earnings may be withdrawn at any time, but may be subject to tax penalties if withdrawn early and not re-deposited into a tax-qualified retirement plan.

Rollover contributions are not eligible for matching employer contributions.

Contribution Limits

Limit on Annual Pre-Tax Employee Contributions

Your pre-tax contribution amounts (other than catch-up contributions) are limited by rules contained in IRC section 402(g). For 2014, the annual limit for 401(k) plan pre-tax contributions is $17,500. This limit is adjusted periodically for inflation. Note that this limit applies to any pre-tax contributions you have made in the same calendar year, including any pre-tax contributions you made under a previous employer's plan. You are responsible for ensuring that your total pre-tax contributions from the combined plans do not exceed the IRC section 402(g) limit.

If you reach the annual limit before the end of the year and want to continue to receive the matching employer contribution for the entire year, you should consider a provision under the Plan called the "spillover election." This election automatically changes your pre-tax contributions to after-tax contributions when you reach the pre-tax limit. You may make the spillover election through Fidelity NetBenefits℠ online account service (www.401k.com) or by contacting Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015). If you make a spillover election, your original pre-tax contribution elections will resume automatically in January of the following year unless you specify otherwise.

Limit on Annual Plan Contributions

All employee pre-tax and after-tax contributions, excluding catch-up contributions, as well as all employer contributions, may not exceed the IRC annual additions limit, which is the lesser of:

(i) 100% of your compensation; or

(ii) a dollar amount specified under IRC section 415 ($52,000 for 2014) as adjusted periodically for inflation.

If you reach the IRC section 415 limit before the end of any calendar year, your contributions to the Plan (except for eligible employee catch-up contributions) will be stopped.

Other Contribution Limits

IRC section 401(a)(17) specifies a dollar limit for annual covered compensation on which contributions may be made, which is adjusted periodically for inflation. The earnings limit for 2014 is $260,000.

In addition, the average contribution percentages made by and on behalf of "highly compensated" employees may not exceed the average contribution made by and on behalf of "non-highly compensated" employees by more than the amounts set forth in IRC section 401(k). In general, employees earning more than $115,000 per year in 2014 are considered highly compensated. This amount is updated periodically.

Corrective Amounts for Excess Contributions

If the IRC section 402(g) or section 401(k) limits described above are exceeded within the Plan, the Plan Administrator will notify you and will refund any excess contributions by April 15 of the year following the year in which the excess contributions were made. Any earnings or losses on refunds of participants' excess contributions will be allocated in accordance with IRS regulations. However, if you are eligible for catch-up contributions, any excess contributions will be re-characterized as catch-up contributions (to the extent allowed by law).

You are responsible for ensuring that your contributions to all employer plans in a single calendar year do not exceed applicable IRC limits. If your contributions to all employer plans do exceed the applicable IRC limits, you must contact the Plan Administrator to request a refund.

Investing

This section describes the different investment options available to you. Specific information about your individual account is available online at Fidelity Investments' website, NetBenefits℠ online account services at www.401k.com, or by telephone from the Fidelity RSP Service Center at 877-PGE-401K (877-743-4015).

Investment and Advisory Services

Financial Engines is an unbiased, independent advisory firm which the Plan Administrator has selected to provide Plan participants with support and assistance in making investment decisions. For a description of the firm's services, see "Financial Engines" on page 409.

Investment Options

The RSP offers a number of investment options for building an individual investment portfolio designed to achieve your retirement savings goals. You should keep in mind several factors when determining your individual investment strategy and deciding which investment funds meet your needs. Primarily, you should weigh your tolerance for risk against your personal savings goals and how long you have to reach them. You should also consider your overall financial picture, including any external personal investments. Regardless of which funds you choose, it is always your responsibility to ensure that your fund choices meet your investment objectives. It is also important to periodically review your investments, your objectives, and the investment options under the Plan to help ensure that your retirement savings will meet your retirement goals.

To help achieve long-term retirement security, you should also give careful consideration to the benefits of a well-balanced and diversified investment portfolio. Spreading your assets among different types of investments can help you achieve a favorable rate of return, while minimizing your overall risk of losing money. This is because market or other economic conditions that cause one category of assets, or one particular security, to perform well often cause another asset category, or another particular security, to perform poorly. The Department of Labor and the Internal Revenue Service advise that if you invest more than 20% of your retirement savings in any one company or industry, such as the PG&E Corporation Stock Fund, your savings may not be properly diversified. Although diversification is not a guarantee against loss, it is an effective strategy to help you manage investment risk.

The Employee Retirement Income Security Act of 1974 (ERISA) imposes certain duties on the parties who are responsible for the operation of the Plan. These parties, called fiduciaries, have a duty to manage Plan assets in a prudent manner. However, an exception exists for plans which comply with section 404(c) of ERISA and permit a participant or beneficiary to exercise control over the assets in his or her account and choose from a broad range of investment alternatives. This Plan is intended to be an ERISA section 404(c) plan. This means that you, not the Plan Administrator, the Company or any other employee, are responsible for investment decisions relating to the assets in your account under the Plan.

Investment information, including prospectuses, fund descriptions and investment performance, can be found by logging on to Fidelity NetBenefits℠ online account services at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

RSP investment options are structured in three tiers:

- Tier 1: Target Date Funds
- Tier 2: Core Funds
- Tier 3: Self-Directed Account

Tier 1: Target Date Funds

Tier 1 provides a suite of eleven individual funds that each provides a broadly diversified portfolio consisting principally of U.S. and international common stock and marketable fixed income securities with an asset allocation that is suitable for a participant with a retirement date in the fund's specified target year. The asset allocation is established by the fund's investment manager and is incrementally adjusted to reflect an appropriate balance of opportunities for growth and stable income relative to the stated target retirement date.

The RSP Retirement Income Fund is designed for investors who have reached their retirement date. The strategy is comprised mostly of bond funds to provide stability and income; it also includes an allocation to equities to provide diversification and some growth during retirement. You should be aware that the RSP Retirement Income Fund will still be exposed to fluctuations in the security markets.

Each Target Date Fund has its own fund description which describes the investment mix and strategy of each fund. These funds are based on well-established investing concepts related to diversification and risk. However, these funds do not guarantee a positive return or adequate funds throughout retirement. Be sure to review the applicable fund description before making your investment decision.

The Target Date Funds are the Plan's default investment option(s). If you do not provide instructions on how you want your contributions invested, they will be invested in the Target Date Fund with a target date closest to your 65th birthday. For participants over age 65, they will be invested in the RSP Retirement Income Fund.

PG&E provides oversight and monitoring of the Target Date Funds investment manager to ensure that the funds remain consistent with their stated objectives. Current information regarding fund performance and fees is available through Fidelity NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

Tier 2: Core Funds

The Core Funds include the following eleven investment options:

- RSP Money Market Fund
- RSP Short Term Bond Index Fund
- RSP Bond Index Fund
- RSP U.S. Government Bond Index Fund
- RSP Large Company Stock Index Fund
- RSP Small Company Stock Index Fund
- RSP Total U.S. Stock Index Fund
- RSP International Stock Index Fund
- RSP World Stock Index Fund
- RSP Emerging Markets Enhanced Index Fund
- PG&E Corporation Stock Fund

PG&E provides oversight and monitoring of the Core Fund managers to ensure that the funds remain consistent with their stated objectives.

RSP Money Market Fund

The Fund seeks to offer safety of principal by investing in short-term government and non-government debt securities.

The Fund invests principally in the following instruments: U.S. Treasury bills, notes and bonds (which are direct obligations of the U.S. government).

An investment in a money market fund is not insured or guaranteed by the Federal Deposit Insurance Corporation (FDIC) or any other government agency. Although the fund seeks to preserve the value of your investment at $1.00 per share, it is possible to lose money by investing in the fund.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

RSP Short Term Bond Index Fund

The Fund seeks to match the returns of the Barclays Capital U.S. 1–3 Year Government/Credit Bond Index.

The Fund is managed using a "passive" or "indexing" investment approach, by which the Fund's investment manager attempts to replicate, before expenses, the performance of the Barclays Capital U.S. 1–3 Year Government/Credit Bond Index (the "Index").

Since it is an index fund, the Fund invests in a well-diversified portfolio that is representative of the short-term domestic bond market.

The performance of the Fund depends primarily on the value of its bond holdings, changes in interest rates, and the credit quality and maturity of its investments. In general, bond prices tend to increase when interest rates decrease, and vice versa. This price fluctuation can produce decreases in principal value if interest rates rise; this effect is often most pronounced for longer maturity bonds. Therefore, the Fund's investment in high-quality bonds with a short-term maturity will generally produce steady income with reduced risk compared with funds that invest in longer maturity bonds.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

RSP Bond Index Fund

This Fund seeks to match the returns of the Barclays Capital Aggregate Bond Index, a benchmark representing the broad, intermediate maturity, investment-grade U.S. bond market.

The Fund invests primarily in government, corporate, mortgage-backed, and asset-backed fixed-income securities of intermediate maturity; all bonds are investment grade.

Since it is an index fund, the Fund invests in a well-diversified portfolio that is representative of the broad domestic bond market.

The performance of the Fund depends primarily on the value of its bond holdings, changes in interest rates, and the credit quality and maturity of its investments. In general, bond prices tend to increase when interest rates decrease, and vice versa. This price fluctuation can produce decreases in principal value if interest rates rise; this effect is often most pronounced for longer maturity bonds. Therefore, the Fund's investment in high-quality bonds with an intermediate-term maturity will generally produce steady income with reduced risk compared with funds that invest in longer maturity bonds.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

RSP U.S. Government Bond Index Fund

This Fund seeks to match the returns of the Barclays Capital US Government Bond Index, a benchmark representing investment-grade fixed income securities issued by the United States government or its agencies.

The Fund invests in a sample of bonds in the Barclays Capital US Government Bond Index in proportion to their weight in the index. All bonds are investment grade. Since it is an index fund, the Fund invests in a well-diversified portfolio that is representative of the U.S. government and agency intermediate maturity bond market.

The performance of the Fund depends primarily on the value of its bond holdings, changes in interest rates, and the credit quality and maturity of its investments. In general, bond prices tend to increase when interest rates decrease, and vice versa. This price fluctuation can produce decreases in principal value if interest rates rise; this effect is often most pronounced for longer maturity bonds. Therefore, the Fund's investment in high-quality bonds with an intermediate-term maturity will generally produce steady income with reduced risk compared with funds that invest in longer maturity bonds.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

RSP Large Company Stock Index Fund

This Fund seeks to match the performance of the Standard & Poor's 500® Index, a benchmark representing the large-capitalization U.S. stock market.

The Fund invests in all 500 stocks in the S&P 500® Index in proportion to their weightings in the index. The S&P 500® Index provides exposure to about 78% of the market value of all publicly-traded common stocks in the United States. The strategy of investing in the same stocks as the S&P 500® Index assures a return similar to the benchmark, minimizes the need for trading, and results in lower expenses.

The performance of the Fund depends on the value of its holdings. Stock values may vary from day to day in response to the corporate performance of individual companies and general market and economic conditions. The Fund is diversified to minimize the impact of underperformance by a single company. In the short term, stock values may be volatile, but over the long term, they have the potential for higher returns than bond or short-term investments.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

RSP Small Company Stock Index Fund

This Fund seeks to match the performance of the Russell Small Cap Completeness Index, a benchmark representing the mid-and small-capitalization sectors of the U.S. stock market.

The Fund invests in all of the stocks in the Russell Small Cap Completeness Index in proportion to their weightings in the index. These stocks represent about 22% of the market value of all publicly-traded common stocks in the United States. The strategy of investing in the same stocks as the Russell Small Cap Completeness Index assures a return similar to the benchmark, minimizes the need for trading, and results in lower expenses.

The performance of the Fund depends on the value of its holdings. Stock values may vary from day to day in response to the corporate performance of individual companies and general market and economic conditions. The Fund is diversified to minimize the impact of underperformance by a single company. In the short term, stock values may be volatile, but over the long term, they have the potential for higher returns than bond or short-term investments.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

RSP Total U.S. Stock Index Fund

This Fund seeks to match the performance of the Russell 3000 Index, a benchmark representing the 3000 largest U.S. companies.

The Fund invests in all of the stocks in the Russell 3000 Index in proportion to their weightings in the index. These stocks represent about 98% of the market value of all publicly-traded common stocks in the United States. The strategy of investing in the same stocks as the Russell 3000 Index assures a return similar to the benchmark, minimizes the need for trading, and results in lower expenses.

The performance of the Fund depends on the value of its holdings. Stock values may vary from day to day in response to the corporate performance of individual companies and general market and economic conditions. The Fund is diversified to minimize the impact of underperformance by a single company. In the short term, stock values may be volatile, but over the long term, they have the potential for higher returns than bond or short-term investments.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

RSP International Stock Index Fund

This Fund seeks to match closely the performance of the Morgan Stanley Capital International World ex-US Index, a benchmark representing the large-capitalization sectors of developed stock markets outside of the United States.

The Fund typically invests in all the stocks in the MSCI World ex-US Index in proportion to their weightings in the index. The strategy of investing in the same stocks as the MSCI World ex-US Index assures a return similar to the benchmark, minimizes the need for trading, and results in lower expenses.

The performance of the Fund depends on the value of its holdings. Stock values may vary from day to day in response to the corporate performance of individual companies and general market and economic conditions. The Fund is diversified to minimize the impact of underperformance by a single company. In the short term, stock values may be volatile, but over the long term, they have the potential for higher returns than bond or short-term investments. Investment in the Fund is made in U.S. dollars; therefore, the Fund is also exposed to fluctuations in foreign currencies.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

You are not allowed to make more than one exchange into or out of the RSP International Stock Index Fund in any 30-day period.

RSP World Stock Index Fund

This Fund seeks to match closely the performance of the Morgan Stanley Capital International World All Country World (MSCI ACWI) Index, a benchmark representing global developed and emerging markets.

The Fund typically invests in a sample of the stocks in the MSCI ACWI Index in proportion to their weightings in the index. The strategy of investing in a sample of the same stocks as the MSCI ACWI Index assures a return similar to the benchmark, minimizes the need for trading, and results in lower expenses.

The performance of the Fund depends on the value of its holdings. Stock values may vary from day to day in response to the corporate performance of individual companies and general market and economic conditions. The Fund is diversified to minimize the impact of underperformance by a single company. In the short term, stock values may be volatile, but over the long term, they have the potential for higher returns than bond or short-term investments. Investment in the Fund is made in U.S. dollars; therefore, the Fund is also exposed to fluctuations in foreign currencies.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

You are not allowed to make more than one exchange into or out of the RSP World Stock Index Fund in any 30-day period.

RSP Emerging Markets Enhanced Index Fund

This Fund seeks to outperform the performance of the Morgan Stanley Capital International Emerging Markets Index, a benchmark representing global emerging markets.

The Fund typically invests in foreign common stocks expected to offer the greatest value in countries determined to be the most attractive based on the investment manager's investment process.

The performance of the Fund depends on the value of its holdings. Stock values may vary from day to day in response to the corporate performance of individual companies and general market and economic conditions. The Fund is diversified to minimize the impact of underperformance by a single company. In the short term, stock values may be volatile, but over the long term, they have the potential for higher returns than bond or short-term investments. Investment in the Fund is made in U.S. dollars; therefore, the Fund is also exposed to fluctuations in foreign currencies.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

You are not allowed to make more than one exchange into or out of the RSP Emerging Markets Enhanced Index Fund in any 30-day period.

PG&E Corporation Stock Fund

This Fund is designed to provide you with an opportunity to own part of PG&E Corporation and to share in the investment performance of PG&E Corporation common stock. PG&E Corporation common stock is listed on the New York Stock Exchange (NYSE) under the symbol "PCG." All matching employer contributions are initially invested in this Fund.

The PG&E Corporation Stock Fund is invested primarily in PG&E Corporation common stock, with a small amount of short-term investments that is held to provide the liquidity needed to accommodate your buy and sell orders on a daily basis.

Under the accounting method used for the Fund, each participant owns units of the Fund rather than shares of stock. Each unit represents an interest in the Fund's PG&E Corporation common stock and a small amount of the Fund's short-term investments.

Each day, the value of each unit is adjusted to reflect each participant's interest in the change in the price of PG&E Corporation common stock, any dividend activity, and interest earned on the short-term investments held by the PG&E Corporation Stock Fund. Dividends are used to either purchase additional units for participants or pay participants in cash (see "PG&E Corporation Stock Fund Information" on page 400).

The Fund is not diversified and effectively invests in a single security. As a result, the Fund's returns will be driven principally by the performance of PG&E Corporation common stock.

PG&E has filed a registration statement with the Securities and Exchange Commission covering the offer and sale of PG&E Corporation common stock under the Plan. In addition to reading this summary plan description, you should read the description of the Fund that is contained in a separate prospectus that is provided along with this summary plan description before investing in the PG&E Corporation Stock Fund. This prospectus is attached at the end of this Summary of Benefits Handbook. Also, be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description and prospectus can be found on NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

Tier 3: Self-Directed Account (Fidelity BrokerageLink)

Tier 3 is a self-directed brokerage account that provides investment choices beyond the funds in Tiers 1 and 2 of the Plan. Through the Self-Directed Account, you can invest in mutual funds available in Fidelity FundsNetwork through the use of Fidelity BrokerageLink.

If you wish to invest in funds that are available through the Self-Directed Account, you must open a BrokerageLink account directly with Fidelity Brokerage Services LLC (or FBSLLC). The terms of the brokerage account, including fees, are established in written agreements between FBSLLC and participants. FBSLLC establishes the terms and provisions applicable to Fidelity BrokerageLink holdings and transactions.

FBSLLC retains full control over the mutual funds made available through Fidelity's FundsNetwork. Mutual funds may be added or closed at the sole discretion of FBSLLC. Neither the Plan Administrator nor PG&E Corporation selects or monitors the offering of specific mutual funds through BrokerageLink or the terms and provisions

applicable to Fidelity BrokerageLink holdings and transactions. Therefore, participants choosing to enroll in BrokerageLink are fully responsible for their investment decisions, including all appropriate research regarding the suitability of investing in any such funds.

You cannot use the Self-Directed Account to invest in PG&E Corporation common stock or in any of the Plan's other Tier 1 or Tier 2 funds. Participant account balances invested in a Self-Directed Account must be exchanged into one or more of the Plan's Tier 1 or Tier 2 funds before such amounts are available for a participant loan, withdrawal or distribution.

For additional discussion of the Self-Directed Account and BrokerageLink, please refer to the BrokerageLink Fact Sheet available under the Plan Information and Documents section, and the BrokerageLink Brochure and materials available under the BrokerageLink section of NetBenefits℠ at www.401k.com. Or, you may contact Fidelity's RSP Service Center at 877-PGE-401k (877-743-4015) and ask to be transferred to a BrokerageLink representative.

PG&E Corporation Stock Fund Information

The Plan contains an Employee Stock Ownership Plan (ESOP). Under the ESOP, participants who hold an investment in the PG&E Corporation Stock Fund on the record date for the payment of a dividend on PG&E Corporation common stock may elect to:

- Reinvest the dividends in additional units of the PG&E Corporation Stock Fund,
- Receive the dividends in cash, or
- Choose a combination of both.

Unless you instruct Fidelity to pay the dividends in cash, dividends will be reinvested in additional units of the PG&E Corporation Stock Fund. Once made, this election remains in effect until changed. You may change your dividend election each quarter. Dividends are payable only with respect to an investment in the PG&E Corporation Stock Fund made at least 3 business days before the dividend record date.

Dividend Election

If you would like to have all of your dividends reinvested, you do not need to do anything. Dividends that are reinvested in additional units of the PG&E Corporation Stock Fund are not taxed until withdrawn.

Dividend Pass Through

If you would like to receive all or a portion of your dividends in cash, you must notify Fidelity Investments at least 10 business days before dividends are paid, excluding NYSE holidays. You may specify the portion of dividends to be paid in cash in 1% increments. To make a dividend election, you are required to call Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015). Each dividend payment is subject to federal and state income taxes in the year in which it is paid; however, no federal or state penalty taxes on early distributions from defined contribution plans will apply.

Voting Rights

If you participate in the PG&E Corporation Stock Fund, you will have the right to vote the proportionate shares of PG&E Corporation common stock held in the Fund that are credited to your account in the Plan as of the proxy record date. The Trustee will send participants the proxy solicitation material issued by the Corporation and a form requesting confidential instructions on how to vote each participant's shares. If you do not direct how to vote your shares, the Trustee will not make any votes with respect to the stock credited to your account.

Monitoring and Making Changes to Your Investments

Because your investment objectives and financial needs change over time, it is important that you have the flexibility and tools to review your account activity and modify your investment periodically.

Fund Transfers and Exchanges

You may log onto NetBenefits℠ at www.401k.com or contact Fidelity's RSP Service Center by calling 877-PGE-401K (877-743-4015) to transfer (exchange) money you have accumulated in the Plan among the various Tier 1 and Tier 2 investment fund options offered through the Plan, as well as into the Self-Directed Account (if you have previously established a Fidelity BrokerageLink account). Prior to initiating an exchange, it is recommended that you carefully review the relevant investment fund descriptions to understand the investment fund characteristics and any restrictions on the frequency of exchanges.

Although matching employer contributions are automatically invested in the PG&E Corporation Stock Fund, you may reallocate matching employer contributions and accumulated earnings thereon to another investment fund or funds at any time once they have been credited to your account, subject to the prohibition against insider trading (see "PG&E Corporation Stock Fund Exchanges" below for more information).

You are not allowed to make more than one exchange into or out of the funds listed below within the specified restriction period:

Fund	Restriction Period
RSP Emerging Markets Enhanced Index Fund	30 day restriction
RSP International Stock Index Fund	30 day restriction
RSP World Stock Index Fund	30 day restriction

Exchanges among the investment funds may be made on a daily basis, in increments of at least 1% of the value of the source investment fund. Exchanges completed before 4 p.m. Eastern time are effective and valued at the close of the NYSE that day. Exchanges completed after the close of the NYSE, normally 4 p.m. Eastern time, or on non-business days, will receive the next available closing price. The amount you are transferring will be credited to your new investment fund choice at the unit (or share value) closing price.

Fund Transfers and Exchanges Involving Self-Directed Account Investments

You cannot make direct exchanges of fund balances invested in any of the funds offered in Tiers 1 and 2 of the Plan to mutual funds available through the Self-Directed Account. Fund balances exchanged from any of the Tier 1 or Tier 2 Core Funds to the Self-Directed Account are deposited as cash into a cash reserve account in the Self-Directed Account. These cash reserve assets can then be used, at your direction, to purchase mutual funds available through the Self-Directed Account. Any fees associated with such transactions are paid from the cash reserve account. Participants wishing to reinvest assets held in the Self-Directed Account into the RSP Tier 1 and Tier 2 Core Funds can only make direct exchanges from a Self-Directed Account cash reserve account to the RSP Money Market Fund. Once such assets are exchanged into the RSP Money Market Fund, they can be exchanged into the other funds available under Tiers 1 and Tier 2, subject to the restrictions discussed above.

Most exchanges between Tier 1 and Tier 2 Core Funds and mutual funds within the Self-Directed Account require a three (3) business day settlement period. You may go through NetBenefits or speak to a BrokerageLink representative to exchange from a Self-Directed Account into the RSP Money Market Fund. When placing a sell order in your Self-Directed Account, you must first liquidate mutual fund holdings within BrokerageLink, which settle to the Self-Directed Account cash reserves. Following each settlement you must go through NetBenefits or call Fidelity back after each settlement to transfer funds from the Self-Directed Account cash reserve account back to the RSP Money Market Fund. Any trade-related expenses (commissions or other fees) and realized loss or gain will be borne by your Self-Directed Account.

Fidelity will liquidate and transfer assets out of the Self-Directed Account to the extent necessary to correct certain problems, including, for example, assets that have been deposited in the Self-Directed Account via an unauthorized channel. An "unauthorized channel" means in any manner other than through a payroll deduction or the exchange of one Plan investment for another. In the event of a correction, Fidelity will look to the Self-Directed Account's cash reserve account first. If that account does not contain sufficient assets, Fidelity will place sell trade orders with respect to your Self-Directed Account investments. Securities will be sold (liquidated) on a last in-first out basis, and be limited to the number of shares necessary to correct the problem.

Fidelity will transfer assets into the Self-Directed Account to the extent necessary to correct certain problems, including, for example, a negative balance in the Self-Directed Account's cash reserve account due to an unsecured debit or overdraft, or assets that have been withdrawn from the Self-Directed Account via an unauthorized channel. An "unauthorized channel" means in any manner other than through the Plan's recordkeeping system. In the event of an unauthorized channel withdrawal, Fidelity will contact you and request that the withdrawn assets be returned to Fidelity. Upon return, those assets will be re-deposited into the Self-Directed Account's cash reserve account. In the event of an unsecured debit or overdraft, Fidelity will look first to your investments in Tiers 1 and 2. If Tiers 1 and 2 do not contain sufficient assets, Fidelity will place sell trade orders with respect to your Self-Directed Account investments.

Securities will be sold (liquidated) on a last in-first out basis, and be limited to the number of shares necessary to correct the problem.

There may be restrictions or trading fees on some funds in the Self-Directed Account. You will need to contact Fidelity's RSP Service Center by calling 877-PGE-401K (877-743-4015) for more information on restrictions.

With respect to exchanges into the Self-Directed Account, if a request is confirmed before the close of the market (generally 4 p.m. Eastern time on non-holiday weekdays), 100% of the exchanged amount will be available for trading on the next business day. However, if the exchange is initiated through a BrokerageLink representative (i.e., not through NetBenefits℠), 90% of the assets will be immediately available to trade through a BrokerageLink representative.

PG&E Corporation Stock Fund Exchanges

Trades into or out of the PG&E Corporation Stock Fund are permitted. However, if you are aware of "inside" information (i.e., information that would be important to an investor, but which has not yet been made public), you are prohibited by federal securities laws and PG&E Corporation policy from trading in the PG&E Corporation Stock Fund until the information has been publicly disseminated.

Executive officers of PG&E Corporation and members of the Board of Directors of PG&E Corporation are subject to additional restrictions with respect to transactions involving the PG&E Corporation Stock Fund in order to ensure compliance with section 16 of the Securities Exchange Act of 1934.

Fidelity will process requests to sell PG&E Corporation Stock Fund units for exchanges, withdrawals, distributions, and loans provided that there are enough short-term investments in the Fund for liquidity. In the unusual event that there are not enough short-term investments for liquidity, requests to sell units will be suspended. As long as the PG&E Corporation Stock Fund remains open and participants have not cancelled the transaction, their requests to sell units will be processed, generally on a first-in-first-out basis, as liquidity is restored in the Fund. Loans and withdrawals will be given priority over exchanges. If a transaction involves a suspended sale of PG&E Corporation Stock Fund units, the entire transaction will be suspended, including the corresponding purchase transaction. Participants will receive the net asset value on the processing date.

Participants who have requested transactions requiring the sale of PG&E Corporation Stock Fund units will need to check their account the following business day to determine whether their request has been processed.

Accessing Your Account

This section describes the rules and process of accessing the funds in your account. Specific information for participants about their individual accounts is available online at Fidelity Investments' website, NetBenefits℠, at www.401k.com, or by telephone from the Fidelity RSP Service Center at 877-PGE-401K (877-743-4015).

Loans

The Plan has a loan feature that gives you access to your money before retirement by letting you borrow from your account at a reasonable rate of interest. You can borrow your money without incurring any immediate income tax liability or early distribution penalties.

As long as you are employed by a participating employer within PG&E Corporation, you are eligible to borrow your money in the Plan. Loans are funded by reducing your Plan balance by the amount you borrow and are secured

by a promissory note between you and the Plan Administrator. Repayments, plus interest, are credited back to your account; in essence, you are borrowing the money from yourself.

Please note that if you have any investments in the Self-Directed Account, those investments must be exchanged into one or more of the Plan's Tier 1 or Tier 2 funds before such amounts are available for a loan or loans.

Loan Terms and Borrowing Limits

Loans with a term of five years or less can be used for any reason. Longer-term loans with repayment periods extending up to 15 years may be taken to purchase a principal residence. Interest on long-term loans is not deductible for income tax purposes; therefore, a conventional home mortgage loan may be more advantageous for participants seeking financing for a principal residence.

There are limits to how much you can borrow and how often. You may have only three loans outstanding at any time, and the maximum amount of principal that can be borrowed or outstanding may not exceed the lesser of $50,000 or 50% of the value of your Plan balance invested in Tier 1 and Tier 2 funds, minus the highest outstanding loan balance in the previous 12 months. The minimum loan amount is $1,000. A loan may not be refinanced during the loan term.

A loan may be funded from several types of contributions (pre-tax, matching employer, after-tax, etc.) depending on your contribution elections. The proceeds to fund a loan from your Plan balance will be deducted from the various types of contributions invested in Tier 1 and Tier 2 funds in the following sequence:

1. Accumulations attributable to any after-tax contributions
2. Accumulations attributable to any rollover contributions
3. Accumulations attributable to matching employer contributions
4. Accumulations attributable to any pre-tax contributions
5. Accumulations attributable to catch-up contributions

Interest Rates

Interest rates for all loans equal the prime rate plus 1%, as determined by Reuters or any successor selected by the Plan Administrator for the month in which the loan is requested. The rate is set when you apply for a loan and remains fixed throughout the duration of the loan.

Fees

There are fees associated with loans. See "Fees" on page 415 for more information.

However, for Participants performing uniformed military service (as defined under federal law), the interest rate will not be higher than 6%, compounded annually to the extent required by federal law.

Electronic Funds Transfer Service

When you request a loan or withdrawal from your account through Fidelity NetBenefits℠ or the RSP Service Center, you can have the proceeds transferred electronically to your bank account instead of waiting for a check. You can also set up or change your bank account information online or through a Participant Services Representative.

If you will be requesting a loan or withdrawal in the future and would like to take advantage of Electronic Funds Transfer (EFT), you will need to have the service established in advance. The set-up process, known as "pre-note," can be initiated online through NetBenefits℠ online account services (www.401k.com) or by calling 877-PGE-401K (877-743-4015) and speaking with a Participant Services Representative, Monday through Friday, 5 a.m. to 9 p.m. Pacific time, and generally requires seven days to complete. To set up EFT, you'll need to have the following information available:

- Social Security Number
- Personal Identification Number

- Name of Bank Name on Bank Account
- Bank Account Number
- Bank Routing Number

Repayment

Generally, you repay a loan through automatic after-tax payroll deductions. If your current payroll contributions are being invested in Tier 1 and/or Tier 2 funds, loan repayments will be credited back to your account according to your current investment election. If all or any part of your current payroll contributions are being invested in the Self-Directed Account, the portion of your loan repayments relating to such contributions will be credited to the Self-Directed Account's cash reserve account. Depending on the type of contributions that were deducted to fund your loan, your loan repayments will be credited in the following sequence:

1. Repayments of accumulations attributable to catch-up contributions
2. Repayments of accumulations attributable to pre-tax contributions
3. Repayments of accumulations attributable to matching employer contributions
4. Repayments of accumulations attributable to rollover contributions
5. Repayments of accumulations attributable to after-tax contributions

The maximum repayment term is five years—or up to 15 years if you are using the loan proceeds to purchase a principal residence.

Cash repayments paid in level installments to Fidelity are required if:

- Your net pay is insufficient to cover a payroll deduction for the full amount from your paycheck;
- You are granted an unpaid leave of absence; or
- You terminate employment with PG&E.

You may also make partial or full cash repayment before the completion of the loan term—without prepayment penalties. Following any partial prepayment, the loan can be re-amortized at your direction to provide for continued level installments for the original loan term.

If you terminate employment with Company, you must make direct payments or elect the EFT service to repay any outstanding loan balance to Fidelity Investments. The Plan Administrator reserves the right to call any participant's loan upon a participant's termination of employment with PG&E or upon termination of the Plan.

Loan Repayment Suspensions

For participants on a leave of absence from the Company, loan repayments may be suspended for the lesser of (i) the leave of absence or (ii) 12 months. The participant must notify the Benefits department when a leave of absence is approved. The participant is responsible to begin payments in the 13th month if the leave extends beyond 12 months. Failure to begin repayments in the 13th month will result in a default notification. If a loan remains in default for more than 30 days after notification, the unpaid principal will be treated as a taxable distribution subject to federal and state income tax and applicable penalty taxes.

If, upon resumption of payments, the suspension period, when added to the original loan repayment period, exceeds the permissible loan repayment limits of five or 15 years, the loan can be re-amortized, at the direction of the participant, to conform to these limits. If the loan is not re-amortized, and would otherwise go beyond the original loan repayment period, the participant will owe the balance in full at the end of the original repayment period.

Suspension of repayment is also allowed during a period when you are performing uniformed military service. Contact Fidelity's RSP Service Center by calling 877-PGE-401K (877-743-4015) for more information.

Loan Defaults and Distributions

A loan is treated as a default whenever a loan payment is not made within 60 days of the date it is due. A participant who is late on a loan payment will have 30 days from the date the Plan Administrator provides written notice of the default to cure the default before it becomes final.

If the past due amounts are not paid within the 30-day grace period, any outstanding principal will be treated as a taxable distribution from the Plan. It may also be subject to early distribution tax penalties.

Deemed Distribution of Plan Loans

A loan is considered a deemed distribution when the loan is in default and the participant is not otherwise eligible to receive a distribution of the loan from the Plan. For purposes of a new loan, the loan that was deemed to be distributed will still be treated as outstanding for as long as the participant remains employed by a participating employer within PG&E. This means that both the number of outstanding loans allowed and the allowable total outstanding balance for all loans will be reduced by the number and value of any loan(s) that have been deemed to be distributed. When a participant has a deemed distribution of a loan, the outstanding principal and accrued interest is reported to the participant and the IRS on a Form 1099-R.

Plan Loans When Your Plan Balance is Distributed

If you terminate employment and request a distribution of your Plan balance, your outstanding loan balance will be considered a part of this distribution. In other words, the value of your outstanding loan will be reported as a taxable distribution from the Plan.

Funding Process and Recordkeeping

You may apply for a loan by logging on to Fidelity NetBenefits℠ online account services at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015). Fidelity will send you the loan application paperwork and process the loan upon receipt of your properly completed application form. Spousal consent is required on the loan application if you are married. The check for the loan proceeds and a Truth-In-Lending Agreement will be issued within three to five business days. Your signature endorsement on the check constitutes your agreement to the terms of the loan. A separate loan account will be established and maintained for each loan, and unpaid loan principal and accrued but unpaid interest on the loan will be reflected for accounting purposes in your loan account.

In-Service Withdrawals

In accordance with Internal Revenue Code (IRC) provisions that govern qualified retirement plans, withdrawals and distributions from the Plan are permitted only as provided below. If you are married, spousal consent is required for any withdrawals, including hardship withdrawals from contribution sources that are subject to special restrictions (see the "Hardship Withdrawals" subsection under this "In-Service Withdrawals" section for more information). All withdrawals are subject to federal and state income tax and possibly tax penalties for early distribution (see "Taxes and Penalties" on page 410). Additionally, there are fees associated with in-service withdrawals (see "Fees and Expenses" on page 415for more information).

Withdrawals from the investment funds, except PG&E Corporation Stock Fund, must be taken in cash unless you elect a direct rollover. A direct rollover is not allowed for hardship withdrawals.

Please note that if you have any investments in the Self-Directed Account, those investments must be exchanged into one or more of the Plan's Tier 1 or Tier 2 funds before such amounts are available for a withdrawal or distribution. However, if there are insufficient assets in Tiers 1 and 2 to make any legally required or other necessary distributions (for example, Minimum Required Distributions discussed below), Fidelity will liquidate investments in your Self-Directed Account and use the assets to make the required distribution.

Source and Sequence of Withdrawals

It is important to realize that when you request a withdrawal, you are requesting that investment units (which are the measure of your interest in the investment funds) be withdrawn and converted to cash to pay for the withdrawal. The source of your withdrawal and the sequence in which it is paid determines the extent to which it is taxable. The Plan Administrator will use the following sequence when making distributions from your account:

1. after-tax contributions made before 1987, plus earnings
2. after-tax contributions made after 1986, plus earnings
3. rollover contributions and earnings
4. matching employer contributions and earnings that have held in the Plan for at least two years, subject to certain exceptions as discussed below
5. eligible pre-tax contributions and earnings
6. eligible catch-up contributions and earnings

After-tax Contributions

There are no restrictions on withdrawals of after-tax contributions and earnings. You may withdraw your after-tax contributions to the Plan and any earnings thereon at any time. Note that earnings withdrawn are taxable, and also may be subject to early distribution penalty taxes.

Rollover Contributions

You may withdraw money you rolled over to the Plan from another qualified retirement plan from a previous employer, plus earnings, at any time. Any taxable amount of your withdrawal is subject to ordinary income tax and may be subject to early distribution penalty taxes.

Matching Employer Contributions

You may withdraw matching employer contributions (plus earnings) that have been in this Plan for at least two full years. For example, if you want to withdraw income attributable to matching employer contributions made at any time in 2013, you must wait until 2016 or anytime thereafter. Exceptions to the two-year waiting period are granted if you:

- become permanently disabled;
- have attained age 59½;
- are a military reservist ordered or called to active duty for a period in excess of 179 days (or for an indefinite period) after September 11, 2001 and before December 31, 2007; or
- have requested and are entitled to receive a hardship withdrawal (see the “Hardship Withdrawals” subsection under “In-Service Withdrawals” on page 405 for more information).

Pre-tax Contributions (Including Catch-Up Contributions)

Withdrawals of your pre-tax contributions to the Plan and any associated earnings are generally restricted while you are employed within PG&E Corporation.

If you are currently employed within PG&E Corporation, you may only withdraw pre-tax contributions and earnings if you:

- become permanently disabled;
- have attained age 59½; or

- are a military reservist ordered or called to active duty for a period in excess of 179 days (or for an indefinite period) after September 11, 2001 and before December 31, 2007; or
- if you are on active military duty for more than 30 days.

If you take a withdrawal of pre-tax contributions and/or earnings, you are automatically suspended from Plan participation and may not resume making contributions to the Plan for six months following the date the distribution was made (see "Suspensions" below for more information).

Hardship Withdrawals

You may take a hardship withdrawal while you are employed within PG&E Corporation only on account of an immediate and heavy financial need. To be eligible for a hardship withdrawal, you must have exhausted all other financial resources—insurance proceeds, liquidation of your other financial assets, cessation of your contributions to the Plan, distribution of dividends from shares hold in the PG&E Corporation Stock Fund, other Plan withdrawals and/or loans, and loans from commercial financial intermediaries. You will also have to provide satisfactory proof of valid hardship to the Plan Administrator.

The following reasons will be considered to be valid hardships:

- to cover unreimbursed medical expenses for the participant, spouse, or dependents (as defined in IRC section 152, without regard to section 152(b)(1), (b)(2) and (d)(1)(B)) or primary beneficiary determined without regard to whether the expenses exceed 7.5% of adjusted gross income;
- the purchase of the participant's principal residence (excluding mortgage payments);
- tuition payments and/or room and board for the next twelve months of post-secondary education for the participant, spouse, dependents, (as defined in IRC section 152) or primary beneficiary;
- payments necessary to prevent foreclosure on the mortgage of, or eviction from, the participant's principal residence;
- to pay expenses for the repair or damage to the participant's or beneficiary's principal residence that would qualify for the casualty deduction under IRC section 165 (determined without regard to whether the loss exceeds 10% of adjusted gross income);
- unreimbursed expenses for the funeral of a participant's parent, spouse, dependent (as defined in IRC section 152) or primary beneficiary; or
- taxes or unreimbursed expenses directly related to the participant's bankruptcy.

Amounts available for hardship withdrawals will follow the withdrawal order described under the "Source and Sequence of Withdrawals" heading, above, including your employer contributions and earnings not otherwise available to be distributed, and your pre-tax contributions, including any catch-up contributions plus earnings accrued on your pre-tax contributions before January 1, 1989. Participants requesting a hardship withdrawal may not request an amount that exceeds the amount actually required to satisfy the immediate financial need. The Plan Administrator will automatically withhold 10% for federal taxes from a hardship withdrawal, unless the participant specifies different withholding. Hardship withdrawals may also be subject to early distribution tax penalties.

Suspensions

If you withdraw your pre-tax contributions while still employed by PG&E or any company within PG&E Corporation or take a hardship withdrawal, you are automatically suspended from Plan participation and may not resume making contributions to the Plan for six months following the date the distribution was made. After the six-month period has expired, you must elect to resume contributions; contributions do not resume automatically unless you are subject to automatic enrollment. If you are subject to automatic enrollment, you will be automatically enrolled as described in "Automatic Enrollment in the Plan" as of the next plan year following the end of your suspension.

Withdrawal Options When You Leave PG&E

When your employment with all employers within PG&E ends, the full value of your account is payable to you. Depending on your account balance, you may elect to leave your money in your account until a later date, or to take a full or partial distribution of your account balance.

A distribution package will be mailed to your home after a 30-day waiting period. The package contains information should you want to withdraw all or a part of your account balance. You may elect to have your distribution transferred to an IRA or other tax-qualified plan, or you may elect to have it paid to you.

If your account balance is $1,000 or less when you retire or leave the employment of the Company, you will receive a letter and a distribution form. You must take a lump-sum distribution of your account balance. If the Plan Administrator does not receive your election form within 60 days from the date on which the materials are mailed to you, your distribution will be sent to you in cash subject to mandatory 20% federal income tax withholding (see "Taxes and Penalties" on page 410).

If your account balance is greater than $1,000 but not greater than $5,000 when you retire or leave the employment of the Company, you will receive a letter and a distribution form. You must take a lump-sum distribution of your account balance. If the Plan Administrator does not receive your election form within 60 days from the date on which the materials are mailed to you, your distribution will be automatically rolled over to a Fidelity IRA in your name and invested in the Fidelity Cash Reserve Fund, which is an investment designed to preserve capital and provide a reasonable rate of return and liquidity.

If your account balance is greater than $5,000 when you retire or leave the employment of the Company, your account may remain in the Plan until you request a lump-sum or partial distribution of your account balance. Although your money can remain in the Plan, you may not make additional contributions or borrow money from your account. However, as long as you maintain a balance greater than $5,000, you may still make transfers among the investment funds or request partial withdrawals or a distribution from your account. Your account will continue to share in any investment gains or losses for the funds in which you are invested (see "Monitoring and Making Changes to Your Investments" on page 400). If you leave employment before retirement age (age 55) and you keep your account in the Plan, you will be charged a recordkeeping fee (see "Fees and Expenses" on page 415 for more information). The fee for 2014 is $53 per year, and is charged to your account quarterly. If you retire and keep your account in the Plan, PG&E will continue to pay the recordkeeping fee on your behalf.

If your account balance is greater than $5,000 when you retire or your employment ends, you may also choose to have distributions paid in equal monthly, quarterly, or annual installments. Payments can begin immediately or at a later date that is specified by you. Payments can be deposited directly into your bank account.

Distributions After Your Employment Has Ended

If you are retired or have terminated your employment with PG&E and have left your account balance in the Plan, you must take a minimum distribution from the Plan by April 1 of the calendar year following the year in which you reach age 70½, or, if later, the year you retire after reaching age 70½. Once minimum distributions have started, you must receive a minimum distribution annually. There is a fee imposed each year that a participant receives a minimum required distribution (see "Fees and Expenses" on page 415 or more information).

Minimum required distributions will be made from your investments in Tiers 1 and 2 of the Plan. However, if there are insufficient assets in Tiers 1 and 2 to make any required distributions and you do not liquidate sufficient funds upon notification of the requirement to do so, Fidelity will liquidate investments in your Self-Directed Account and use the assets to make the required distribution. In such a case, Fidelity will look to the Self-Directed Account's cash reserve account first. If that account does not contain sufficient assets, Fidelity will place sell trade orders with respect to your Self-Directed Account investments. Securities will be sold (liquidated) on a last in-first out basis, and be limited to the number of shares necessary to make the required distribution.

The Plan Administrator will notify you if you are subject to required minimum distributions. The Plan Administrator can perform a default calculation (based on Single Life Expectancy) to determine the amount that will satisfy your minimum required distribution. Alternatively, you may make a one-time election to direct the Plan Administrator to use other assumptions (such as Joint Life Expectancy) in the calculation of your required distribution.

Note that minimum required distributions paid from the Plan satisfy the requirements for this Plan only. If you have money invested in other employer-sponsored pension plans or IRAs, minimum required distribution for those plans or retirement accounts must be satisfied independently of the requirements for this Plan.

Investment and Advisory Services

The Plan offers a range of investment and advisory services to help you become a more informed investor and provide access to expert financial guidance.

These services are provided for informational and educational purposes only. Keep in mind that investing involves risk. The value of your investment will fluctuate over time and you may gain or lose money. Always consider carefully the investment objectives, risk, charges, and expenses of any investment option before investing.

Financial Engines

Financial Engines is an unbiased, independent advisory firm which the Plan Administrator has selected to provide Plan participants with support and assistance in making investment decisions. Financial Engines provides two basic types of assistance.

On-Line Advice

Financial Engines' On-Line Advice service is an internet-based interactive service that can help you:

- Build an investment strategy;
- Get advice on which investments to select in Tiers 1 and 2 of the Plan; and
- Monitor your account over time.

You can access On-Line Advice through Fidelity NetBenefits℠ at www.401k.com by selecting the Financial Engines link. There is no cost to you for using On-Line Advice since PG&E pays the full cost of this service.

Professional Management

You have the option to enroll in Financial Engines' Professional Management. If you enroll in Professional Management, you are retaining Financial Engines as your own investment advisor. There are fees associated with this service (see "Fees and Expenses" on page 415 for more information).

As your investment advisor, Financial Engines will:

- Create a retirement savings strategy for your Plan investments;
- Professionally manage your account for you, including directing Fidelity to carry out investment transactions on your behalf; and
- Provide you with quarterly progress reports.

Fees for Professional Management will be deducted quarterly from your Plan account based on the assets in your account that are under professional management. Please read about applicable fees at www.financialengines.com/forpge.

The specific terms of your relationship with Financial Engines are set forth in the customer agreement that you enter into directly with Financial Engines. If you enroll in Professional Management, you may terminate at any time by contacting Financial Engines.

Professional Management Income+

If you're enrolled in Professional Management, you can take advantage of Fidelity's Income+ service if you're age 60 or within five years from retirement.

- Help with preservation. Get help with managing your account with a goal of balancing growth with safety. Fidelity will provide you with an updated Retirement Plan that shows the adjusted investment strategy for your PG&E account.
- Help with planning. Speak to a Professional Management Income+ Investment Advisor Representative for a Retirement Checkup. Review when you might be able to retire, what sources of income you'll have in retirement, and how much you may be able to spend.
- Help with payouts. At your request, the service can also provide monthly payouts from your PG&E Corporation Retirement Savings Plan account that can last throughout your retirement.

If you enroll in Professional Management, Financial Engines has responsibility as a fiduciary to you for the advice and management it provides. Neither the Plan Administrator nor the Corporation is responsible for the results or advice provided by Financial Engines. During the time that you are enrolled in Professional Management, Financial Engines will make all investment decisions with respect to your account. You will not have the ability to make or implement investment decisions directly until you terminate your relationship with Financial Engines.

Financial Engines will only manage investments in Tiers 1 and 2 of the Plan. If you have investments in the Self-Directed Account (Tier 3) at the time you enroll in Professional Management, you may maintain your balance in the Self-Directed Account, but you will be responsible for the investment of these assets. During the time you are enrolled in Professional Management, you will not be permitted to make additional payroll contributions into any mutual funds available through the Self-Directed Account.

For more information about retaining Financial Engines as your investment advisor, including fees for the Professional Management service, please contact Fidelity's RSP Service Center by calling 877-PGE-401K (877-743-4015), or visit www.financialengines.com/forpge.

Fidelity Education and Modeling Tools

Fidelity offers a number of education and modeling tools to help you manage your account. You can access:

- Planning tools to help determine if you are on track to meet your retirement and savings goals;
- Articles on timely savings and retirement topics;
- Calculators to help with financial questions, such as the impact of transactions, such as loans and withdrawals.

Learn more about these resources by logging on to Fidelity NetBenefits℠ online account services at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

Taxes and Penalties

The taxable portion of Plan withdrawals and distributions is generally taxed as ordinary income in the year it is received. Further, withdrawals taken before age 59½ may be subject to nondeductible penalty taxes, unless you qualify for an exemption.

The taxable portion of virtually all non-periodic Plan withdrawals (other than hardship withdrawals) is also subject to mandatory 20% federal withholding tax, unless you arrange to directly roll over the money into an IRA or to another qualified retirement plan.

Certain lump-sum distributions from the Plan may be eligible for special tax treatment if you meet age and participation requirements. If you were born before 1936, you may be eligible for ten-year forward income averaging when you retire if you take a total withdrawal of your account balance. If you think you may be eligible for forward income averaging, you should consult a tax advisor prior to retirement.

Your Plan withdrawals and distributions will be reported annually on Forms 1099-R, which are mailed in January following the year in which the distribution was paid. You are responsible for reporting the taxable amount as income when you file your income tax returns.

When you request a withdrawal or distribution from the Plan, you will receive tax information regarding your income tax liability. You should read this information carefully to understand your payment options and how the manner in which you elect to receive your distribution affects your taxes and tax withholding. If you choose to take a withdrawal or distribution, you are responsible for complying with Internal Revenue Code rules governing distributions from retirement plans and for any tax consequences, and are strongly encouraged to consult a tax advisor. The Plan Administrator is not responsible for advising participants as to the tax consequences of withdrawals or distributions.

Withdrawals of PG&E Corporation Stock

For any withdrawal of contributions and earnings you have invested in the PG&E Corporation Stock Fund, you may have the total amount converted to PG&E Corporation common stock or paid to you in cash. Withdrawals from all of the other investment funds must be taken in cash, unless you elect a direct rollover. If you want to receive PG&E Corporation stock instead of cash from such other funds, you may exchange all or a portion of your money in the other investment funds for units in the PG&E Corporation Stock Fund before taking the withdrawal.

If you withdraw PG&E Corporation stock, you will only be liable for income taxes on the cost basis of each unit. The cost basis is the average purchase price for all the units you own in the Fund. If you sell the withdrawn shares, you will be liable for income taxes on the difference between the cost basis of your units and the sale price. The income will be subject to the capital gains tax rate if you held the shares for at least one year before the sale.

Participants who are considered "affiliates" of PG&E Corporation may generally resell their shares of PG&E Corporation common stock in compliance with the Securities and Exchange Commission Rule 144.

Rollovers

Most taxable and non-taxable withdrawals and distributions from the Plan are eligible for direct rollover to an IRA or other qualified employer retirement plan that accepts rollovers. There are two types of rollovers – direct rollovers and indirect rollovers. A direct rollover is when the check for your Plan balance is payable directly to the receiving IRA or tax-qualified plan. If you choose a direct rollover of the taxable or non-taxable portion of a Plan distribution:

- no taxes will be withheld when the distribution is paid;
- the distribution will not be reported as taxable income; and
- taxes will be deferred until you later withdraw the money from the IRA or recipient qualified employer plan.

An indirect rollover is when the check for your Plan balance is made payable to you, and you then deposit all or a portion of that amount in an IRA or qualified plan. If you request an indirect rollover, the Plan is required by law to withhold 20% of the taxable amount. When you file your income tax return for that year, you must report the total amount of the distribution, including the withheld tax. You will receive a credit for the tax withheld to help offset the income tax you owe for that year. If you take an indirect rollover, you have 60 days from the date that you receive the distribution to roll it over to an IRA, Roth IRA or other qualified plan. Also, if you roll over taxable amounts to a Roth IRA, you will be subject to income tax on those conversions.

Plan distributions that are not eligible for rollover include:

- refunds of automatic enrollment contributions within 90 days of enrollment;
- ESOP dividends;
- loans treated as deemed distributions;
- distributions that are part of a series of substantially equal payments made at least once a year over a period of your lifetime/life expectancy, your and your beneficiary's lifetimes/life expectancies, or 10 years or more;
- minimum required distributions from the Plan;

- hardship withdrawals; and
- refunds of excess contributions.

Although PG&E Corporation stock may be an eligible rollover distribution from the Plan, some IRAs and qualified retirement plans may not accept rollovers of stock certificates. Before requesting a direct rollover of stock certificates, you must verify with the recipient IRA trustee or plan administrator that the IRA or plan will accept a direct rollover of stock certificates.

Early Distribution Penalties

In addition to being taxed as ordinary income, distributions taken before age 59½ (early distributions) may be subject to nondeductible federal and state penalty taxes (currently a 10% federal and 2½% California state tax; penalty taxes in other states may differ). Early distributions are exempt from the penalty taxes if made for one of the following reasons:

- refunds of automatic enrollment contributions within 90 days of enrollment;
- ESOP dividends;
- loans treated as deemed distributions;
- after termination of employment during or after the year in which you reach age 55;
- on account of your permanent disability;
- after termination of employment in a series of substantially equal periodic payments, based on your life expectancy, and continuing for at least five years or until age 59½, whichever is later;
- after qualified service as a reservist (those called to active duty for 180 or more days);
- to cover unreimbursed medical expenses for you, your spouse, or dependents in excess of 7.5% of your adjusted gross income;
- to an alternate payee under a Qualified Domestic Relations Order (QDRO) upon dissolution of marriage;
- to roll over to an IRA or other qualified retirement plan either directly or within 60 days of receipt of the distribution; or
- on account of your death.

The early withdrawal penalties also apply to all hardship distributions except for those taken for unreimbursed medical expenses to the extent that they exceed 7.5% of your adjusted gross income.

The Plan Administrator does not withhold or assess any early distribution penalties when a distribution is paid. If you are subject to the early distribution penalties, you are responsible for including the penalties when you file your income tax return.

What Happens

This section provides general information about how your benefits may be affected by certain life events. Where appropriate, it offers tips about things you may want to consider, actions you may want to take and sources where you can find more information.

In this section you can find information about actions you may take:

If You Are on an Authorized Leave of Absence

Authorized leaves of absence include, but are not limited to, absences due to:

- illness or injury;
- qualified military service; or
- short-or long-term disability.

Your participation in the Plan continues as long as your authorized leave of absence does not constitute a break in service. You may continue making employee contributions and receiving employer matching contributions on any covered compensation you receive while on authorized leave of absence.

You may apply for an in-service or hardship withdrawal depending on your account assets, and the type of withdrawal (see the "Hardship Withdrawals" subhead under "In-Service Withdrawals" on page 405 for more information. You must meet all Plan and Internal Revenue Code requirements for the requested withdrawal. You may not take a distribution from the Plan while on an authorized leave of absence (see "Distributions After Your Employment Has Ended" on page 408).

If you have an outstanding loan, you may need to arrange for a loan repayment suspension, or arrange to make direct payments to Fidelity to repay the loan while you are on leave (see the "Repayment," "Loan Repayment Suspensions" and "Loan Defaults and Distributions" subheads under "Loans" on page 402 for more information). You may not initiate a new loan while on an unpaid leave of absence.

If You Leave PG&E or Retire

If you terminate your employment with PG&E, you may no longer contribute to the Plan, except for contributions made with respect to retroactive wage payments. You may elect full distribution of your account after your employment ends. You may elect to:

- leave assets in the Plan (subject to minimum account distributions and potential ongoing administrative fees);
- rollover your account balance to an IRA or another employer's plan; or
- take a distribution (subject to taxes and penalties).

See the "Withdrawal Options If You Leave PG&E" subhead under "In-Service Withdrawals" on page 405, "Distributions After Your Employment Has Ended" on page 408, and "Taxes and Penalties" on page 410 for additional information.

Administrative Fees

If your employment ends before reaching retirement age (age 55), and you elect to maintain your balance in the Plan, your Plan account will be assessed an administrative fee for the maintenance of your account. This administrative fee does not apply to employees or retirees (employees who are age 55 or older when employment ends). See "Fees and Expenses" on page 415 for more information.

Loans

You may make direct payments or elect EFT service to repay any outstanding loan balance to Fidelity. The loan will default if a loan payment is not made within 60 days of the date it is due. Defaulted loans are treated as plan distributions and are subject to ordinary income taxes. Early distribution penalty taxes may also apply. You cannot take out a new loan once your employment with PG&E ends.

If You Die

If you die, your Plan balance is payable to your beneficiary. If you are married at the time of death and did not designate a different beneficiary with the notarized consent of your spouse, your spouse is automatically your beneficiary. If you are single and did not designate a beneficiary, your estate is your beneficiary. Once the Plan is notified, your spouse or beneficiary will receive his or her options for disposition of the account. Your spouse or

beneficiary may elect either to take a lump-sum distribution or to roll the Plan balance over directly into an inherited IRA. For the purposes of the Plan, you have a "spouse" if you are legally married under applicable law of a state or foreign jurisdiction, including a same-sex couple. However, in accordance with IRS guidance, a registered domestic partnership, civil union, or other similar formal relationship that is not denominated as a marriage under the law is not treated as legally married for purposes of the Plan.

Payment to your beneficiary will occur within 60 days of the Plan Administrator's receipt of your beneficiary's payment instructions. If your beneficiary does not provide payment instructions for disposition of the account within 180 days following the Plan Administrator's receipt of notification of your death, the Plan Administrator will automatically withhold 20% from the taxable portion of the distribution for federal taxes and distribute the remainder to your beneficiary in a lump sum (see "Taxes and Penalties" on page 410).

You may change your beneficiary designation at any time by logging onto NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

If You Transfer to or from a Union Classification

If you transfer to or from a union classification and participate in the Final Pay Pension, be aware that your eligible company matching contributions may change. Also, loan repayments may be re-amortized and may change the frequency of your payments.

If You Get Divorced

Once the divorce is finalized, you may want to change your beneficiary designation. If your former spouse was previously listed as your beneficiary (and you have not designated a different beneficiary), your Plan balance will remain payable to your former spouse on your death. You can change your beneficiary designation at any time by logging onto NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

If your former spouse has a community property interest in your Retirement Savings Plan account, you should submit your endorsed-filed Qualified Domestic Relations Order (QDRO), to the PG&E Law Department for review and implementation. If you have a pending divorce order — referred to as a Domestic Relations Order or "DRO" — you may be restricted from taking withdrawals and distributions from your account until the QDRO is finalized. See additional information regarding QDROs under "Qualified Domestic Relations Orders (QDROs)" on page 418.

If You Get Rehired

If you leave the employment of PG&E after completing one year of service and are subsequently rehired, you will receive credit for your past service, and the matching employer contribution will be based on your total years of service at the time you are rehired.

If you leave PG&E before completing one year of service and you return within 12 months, you will receive credit for your past service toward the one-year service requirement for matching employer contributions. If you leave PG&E before completing one year of service and you are gone for 12 months or more, you must work for 12 months before you are eligible for matching employer contributions.

If you are rehired on or after January 1, 2013 and have one or more years of service, you will be automatically enrolled in the Plan and will receive matching employer contributions of $0.75 per dollar on up to 8% of pay. See "Matching Employer Contribution" on page 391 and "Automatic Enrollment in the Plan" for more information.

Additional Plan Information

This section describes a number of regulations that apply to the benefits described in this Handbook, and provides some administrative details about the plans. For further information on these and other rules, see the *Rules, Regulations and Administrative Information* section.

Significant Accounting Policies and Investment Disclosure

Participants' contributions to the investment funds offered under the Plan are credited to participants' accounts as "units," rather than individual purchases of stocks, bonds, or other securities. The gains or losses in investment fund values are accounted for through increases or decreases in the value of the units. Similar to mutual fund share prices, unit values change daily, taking into account the current fair market value of the investment portfolio, including any earned interest or dividend income, and are determined by dividing the net assets of the fund by the number of units outstanding.

Fees and Expenses

Beginning January 1, 2012, participants who are no longer employed at PG&E but continue to have a balance in the Plan are assessed an administrative fee for as long as they keep an account in the Plan. This fee, which may increase in the future, currently is $53 per year ($13.25 per quarter). The fee will be deducted from your account at the beginning of each quarter and will be reflected on your quarterly statement. This fee applies only to employees who terminate their employment at PG&E but decide to maintain their RSP account. It will not apply to PG&E employees or retirees (employees who were age 55 or older at employment termination).

If you have an account in the Plan, and you select or execute the following service(s) or transaction(s), the fee(s) outlined below are deducted from your account. As you review this information, please keep in mind that fees are subject to change and that certain individual fees may not be deducted in some circumstances.

Type of Fee	Amount
Prior Loan Maintenance Fee	$15.00 per year per loan initiated prior to 11/01/2009, deducted quarterly.
Loan Setup Fee	$50.00 per loan
In-Service Withdrawal Fee	$25.00 per transaction
Minimum Required Distribution Fee	$25.00 per distribution year
Loan Maintenance Fee	$25.00 per year per loan initiated on or after 11/09/2009, deducted quarterly
Overnight Mailing Fee	$25.00 per transaction
Financial Engines Professional Management Fee	If you utilize this service, the Financial Engines fee is as follows: 0.50% per year for the first $100,000.00 in your account; 0.45% per year on the next $100,000.01 to $250,000.00; 0.30% per year for any amount over $250,000.00 and is deducted quarterly.

Investment management and trust expenses are netted against investment returns of Tier 1 and Tier 2 funds. Mutual fund fees and expenses are netted against investment returns for mutual funds in Tier 3. Administrative costs (with the exception of loan fees and Financial Engines' Professional Management fees) are generally paid by PG&E Corporation or participating employers, however, the Plan Administrator may use Plan assets that have been forfeited and are not allocable to individual accounts to pay the reasonable, administrative expenses of the Plan. Additional fee and expense information is provided in the Participant Disclosure Notice that is provided to you each year.

The fund descriptions and more information on fees and expenses can be found on Fidelity NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015). The automated voice response system is available 24 hours a day. You can speak with a Participant Services Representative Monday through Friday from 5 a.m. to 9 p.m. Pacific time.

Plan Administration and the Corporation's Power and Duties

The PG&E Corporation Employee Benefit Committee is the Plan Administrator and is responsible for the overall administration of the Plan. This committee has the sole power and discretionary authority to establish, and from time to time revise, such rules and regulations as may be necessary to administer the Plan in a nondiscriminatory manner for the exclusive benefit of participants and all other persons entitled to benefits under the Plan. This committee delegates to the Senior Vice President – Human Resources of PG&E Corporation and assigned staff the authority to interpret, implement, and revise rules and regulations as necessary to administer the Plan in a proper and nondiscriminatory manner. Staff is also responsible for overseeing participant recordkeeping, accounting, reporting, and receipt and disbursement of Plan assets.

The Plan Administrator 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.

Participant Account Activity and Plan Service Provider

Individual accounts are maintained for each participant's interest in the Plan and all contributions are accounted for separately with respect to units attributable to pre-tax contributions, after-tax contributions, basic employer contributions, matching employer contributions, catch-up contributions, and any rollover contributions. As previously stated, separate accounts are also maintained for participants with an outstanding Plan loan balance.

Quarterly statements of account activity, reflecting contributions and earnings/losses in each investment fund and summarizing transactions during the period, are mailed to each participant as soon as practicable after the end of each quarter. You may also request to receive quarterly statements online.

Fidelity is the administrative service provider for the Plan, and is charged with day-to-day recordkeeping and participant account maintenance. Participant accounts are valued daily with up-to-date account values and share prices, and transactions may be initiated on a daily basis.

Participant services include:

- 24-hour Internet access through Fidelity NetBenefits℠ online account services (www.401k.com).
- 24-hour toll-free telephone automated voice response system; and
- Participant Services Representatives who are available from 5 a.m. to 9 p.m. Pacific time, 6 a.m. to 10 p.m. Mountain time, 7 a.m. to 11 p.m. Central time, and 8 a.m. to midnight Eastern time at Fidelity's RSP Service Center (877-PGE-401K or 877-743-4015).

Claims and Appeals Procedures

If you have a claim for benefits that cannot be resolved through Fidelity's RSP Service Center, you may file a claim for benefits in writing with the Plan Administrator. Claims should be submitted to:

The Retirement Savings Plan Administrator
PG&E Corporation
1850 Gateway Boulevard, 7025C
Concord, CA 94520

If a claim by a participant or beneficiary is denied in whole or in part, the Plan Administrator will notify the claimant in writing, explaining the reason for 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 for the denial;
- the Plan provision on which the denial is based; and, if necessary,
- any explanation or information that may be beneficial to the claimant in order to perfect the claim.

The notice will also include instructions about how to appeal the Plan Administrator's denial and request that the claim be reviewed, including a statement of your right to bring a civil action under ERISA section 502(c) following an adverse benefit determination on appeal. If you do not receive a notice of denial of your initial claim, you may submit a written request for review to the Plan Administrator within these time periods.

A claimant's appeal for review must be made in writing within 90 days of receiving the Plan Administrator's notice of denial. As part of your appeal, you will (1) have the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits; and (2) be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relating to your claim for benefits. The review of your claim will take into account all comments, documents, records, and other information you submit relating to your claim, without regard to whether it was submitted or considered in the initial benefit determination. Failure to raise issues or present evidence on review will preclude those issues or evidence from being presented in any subsequent proceeding or judicial review of the claim.

A final written decision will be rendered within 60 days of receipt of the appeal for review unless due to special circumstances an additional 60 days is required. Your claim is considered approved only if the Plan Administrator's approval is communicated to you in writing.

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 instead of the appeals procedures described above.

The administrative remedies described in this section (as well as a grievance or adjustment procedure of the appropriate collective bargaining agreement if it is used instead of the appeal rights described above) must be exhausted before any legal action can be taken by a claimant. If a claimant timely exhausts all levels of appeal available to the claimant under the Plan's claims procedures (including appeals to both the Plan Administrator and the EBAC), any permissible legal action under ERISA section 502(a) must be initiated within the applicable statute of limitations. The review procedures described in this section are the exclusive administrative procedures provided under the Plan.

Borrowing, Pledging, and Assigning Interests in the Plan

No participant or beneficiary may borrow against, pledge, or assign—voluntarily or involuntarily, or by operation of law—any interest in the Plan or in any distribution to be made under the Plan. However, this does not prevent an employee from obtaining a loan from his or her Plan account in accordance with the Plan's loan procedures. Also, a spouse, former spouse, child, or other dependent of an employee may be able to claim an interest in an employee's Plan benefits under a QDRO issued by a court (see "Qualified Domestic Relations Orders" below). If a participant files for personal bankruptcy, an exclusion and certain exceptions under the bankruptcy law may be applicable to part or all of the participant's Plan account.

Except as described above, no party, including creditors of PG&E Corporation, has or may create a lien on any funds, securities, or other assets held under the Plan.

Future of the Plan

Although the Corporation expects the Plan to continue indefinitely, it has the exclusive right to amend, suspend, or terminate the Plan at any time. No amendment to the Plan may be made, however, that would result in a participant's or beneficiary's loss of rights or accumulated Plan assets. Further, in the event of Plan termination, all contributions to the Plan will stop, but the Plan will continue to operate until all of the assets have been distributed in accordance with Plan provisions in effect on the date of its termination.

Qualified Domestic Relations Orders (QDROs)

In the event a participant is divorced, ERISA permits the division of the participant's Plan account between the participant and certain other beneficiaries pursuant to a QDRO. The Plan Administrator will determine the qualified status of any domestic relations order for a participant who is divorced or legally separated. The Plan will also oversee the disbursement of Plan assets to the participant and the spouse, former spouse, child, or other dependent named in a QDRO as having a right to receive benefits in the Plan.

Domestic relations orders include any judgment, decree, or order (including approval of a property settlement agreement) that relates to child support, alimony payments, or marital property rights and that is made pursuant to state domestic relations laws (including community property law). You can obtain a free copy of the QDRO procedures or a sample QDRO by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-HELP (415-973-4357) or toll-free at 800-788-2363. You can also send an e-mail to the HR Service Center at hrbenefitsquestions@exchange.pge.com.

Once the divorce is finalized, you may want to change your beneficiary designation. You can change your beneficiary designation at any time by logging onto NetBenefits℠ at www.401k.com or by calling Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015).

Facility of Payment

If you are entitled to any payment under the Plan, and the Plan Administrator determines that you are physically or mentally incompetent and no guardian or conservator has been appointed to receive your payment, the Plan Administrator may make payments on your behalf to a third-party to be applied for and on behalf of and for your benefit. Payments made on your behalf will completely discharge the Plan's responsibility for the amount of the payment.

No Guarantee of Employment

Participation in the Plan does not guarantee your right to employment with PG&E Corporation or any affiliates. Further, nothing set forth in this Summary of Benefits Handbook should be interpreted to give you or your beneficiary any legal or equitable rights against PG&E or its affiliates.

Military Service

Federal law provides rights to certain reemployed veterans for service credit and makeup contributions for all or a portion of the period of military service. Please contact Fidelity's RSP Service Center at 877-PGE-401K (877-743-4015) for more information.

Missing Participants

If the Plan Administrator is unable to locate a Participant after three years and after reasonable efforts have been made to do so, the Participant's benefit under the Plan will forfeited and used to offset future employer contributions. If a proper claim is subsequently presented, the Participant's benefit will be reinstated.

Requests for Documents

Participants may review the Plan document, the Trust Agreement between the Corporation and Fidelity Management Trust Company, Investment Agreements between the Corporation and the investment managers, and the Summary Plan Description and any amendments or changes to the provisions contained in these documents at the office of the Plan Administrator. Any report regarding the Plan filed with the Department of Labor, the Internal Revenue Service, or any other governmental agency is also available for review. Requests for copies of any of these documents must be made to the Plan Administrator as follows:

Employee Benefit Committee of PG&E Corporation
1850 Gateway Boulevard 7025C
Concord, CA 94520

The Plan Administrator reserves the right to charge for providing such copies up to the amount permitted under ERISA.

Copies of PG&E Corporation's latest annual report to shareholders, proxy statement, reports, and other communications sent to shareholders, are available without charge upon oral or written request to the Plan Administrator. Requests may be directed to:

PG&E Corporation
Corporate Secretary
77 Beale Street, 24th floor
Mail Code B24W
San Francisco, CA 94105

Retiree Medical Coverage

Upon retirement, you may choose to continue medical coverage under the PG&E Retiree Medical Plan if you meet the eligibility requirements. In general, the dependents you cover as an employee will also continue to be eligible to be covered under your retiree plan.

You must complete the Retiree Medical Election Form and return it to the HR Service Center at least 30 days before your retirement date, even if you are electing to delay your pension. If the form is not received by the HR Service Center on time, your medical coverage will be cancelled as of your retirement date. If your coverage is cancelled, you must wait until the next Open Enrollment period to re-enroll in a PG&E-sponsored retiree medical plan.

If you do not want to continue your PG&E-sponsored medical coverage, you may elect to decline Retiree Medical Plan coverage. However, if you decline coverage, you can re-enroll only during an Open Enrollment period.

If Your Coverage Is Cancelled or You Decline Coverage

To enroll during Open Enrollment, you must call the HR Service Center by **September 1** to notify the Center of your intent to re-enroll for the upcoming calendar year.

Your Medical Plan Options

Medical plan options change from time to time. For retirees, some of the plans offered may be different than the plans available to active employees. Medicare eligibility affects PG&E medical plan eligibility for both employees and retirees.

When you become eligible for Medicare, you will be given the opportunity to change medical plans. Whether you change plans at that time or stay in the same plan, Medicare will become the primary payer and PG&E will become the secondary payer. This means that your monthly contributions will change. As a retiree covered under a PG&E medical plan, you will automatically receive Medicare information before you turn 65. You will also automatically receive Medicare information before your covered spouse or domestic partner turns 65. In addition, when you and/or your covered spouse or domestic partner enroll in Medicare and provide documentation of such enrollment to PG&E, you will receive a monthly credit toward the cost of Medicare Part B premiums for each Medicare enrollee covered in a PG&E-sponsored medical plan.

Eligibility

You may participate in the PG&E Retiree Medical Plan only if you are a Retiree as defined under the PG&E Retiree Medical Plan and you meet the eligibility criteria stated below. There is no retiree dental or vision coverage.

For PG&E Employees

If you are a PG&E employee, you are eligible for Retiree Medical Plan coverage if you:

- attain age 55 prior to your termination or retirement from the Company; and
- you satisfy the applicable Service Requirements outlined below.

Service Requirements

If you are a union-represented employee who terminated employment on or after January 1, 2004, you must satisfy the age requirement above and have a minimum of 10 years of Credited Service under the PG&E Retirement Plan.

Individuals Who Terminate Employment Before Age 55

You are not considered a Retiree of the Company (or of a participating employer) and you are **not** eligible for Retiree Medical Plan benefits or Postretirement Life Insurance benefits if you leave the Company before age 55, even if you have a vested benefit under the PG&E Retirement Plan when you leave the Company (or any participating employer). Although you may be entitled to a benefit from the Retirement Plan, you are **not** eligible for any other benefits such as Retiree Medical or Postretirement Life Insurance.

Surviving Dependents

Surviving Dependents (spouses, domestic partners, and/or eligible dependent children) of an employee or retiree of the Company (or participating employer) are eligible for continued medical plan coverage if they were enrolled in a PG&E-sponsored medical plan at the time of the employee's or retiree's death, as long as they are not covered under another group plan, other than Medicare. Surviving Dependent children must also continue to meet the eligibility required for dependent children.

A Surviving Dependent's coverage begins the month after the death of the Retiree or employee. Required monthly premium contributions will change because the Company does not contribute toward the cost of Surviving Dependent medical coverage unless the survivor has a Retiree Medical Savings Account balance. See Retiree Medical Savings Account (RMSA) for details.

Surviving Dependents who get married or register a domestic partnership are no longer eligible to be covered under a PG&E-sponsored medical plan, even if the new spouse/domestic partner has no other medical coverage. If you get married or register a domestic partnership, please notify the HR Service Center immediately to avoid penalties.

Changing Your Coverage

Each fall, you will have the opportunity to make changes during the Open Enrollment period. In addition, the same change-in-status events that trigger mid-year enrollment changes for active employees — such as marriage, divorce, birth of a child, dependent reaching the limiting age, death of a dependent, moving out of a medical plan's service area, etc. — will also apply to you as a retiree. However, you must be currently enrolled in a PG&E-sponsored medical plan to be eligible to request a benefit change due to a change-in-status event.

Re-enrolling After Cancelling Coverage

All retirees who cancel medical plan coverage on or after January 1, 2003, are allowed to re-enroll in a Company-sponsored medical plan during any subsequent Open Enrollment period. During the time you have waived coverage, events which would otherwise be change-in-status events will not apply to you and you must wait for Open Enrollment to re-enroll. You must notify the HR Service Center of your intent to consider rejoining a medical plan by **September 1** to request an Open Enrollment package for the upcoming calendar year. If you are not enrolled in a PG&E-sponsored retiree medical plan, you will not receive enrollment materials automatically. Notification received after September 1 will be deferred to the following year's Open Enrollment period.

Retirees who dropped or had never enrolled in a PG&E-sponsored retiree medical plan prior to January 1, 2003, are not eligible to re-enroll for Company-sponsored medical plan coverage. Surviving Dependents who cancel medical plan coverage are not eligible to enroll in a PG&E-sponsored medical plan again at any time in the future.

Retiree Medical Savings Account (RMSA)

If you are eligible for PG&E-sponsored retiree medical coverage and you retire in 2011 or later, you and PG&E will share the cost of Retiree Medical Plan coverage. To help you and your eligible spouse or registered domestic partner pay for Retiree Medical Plan premiums, PG&E offers a Retiree Medical Savings Account (RMSA).

What Is the RMSA?

The RMSA is a notional account that you can use to reimburse yourself for the cost of Retiree Medical Plan premiums. When you retire, PG&E establishes separate RMSAs for you and your eligible spouse or registered domestic partner. RMSA funds are available only to help pay for your PG&E-sponsored retiree medical coverage. The account cannot be used for anything else.

Other RMSA Facts

- You never pay taxes on PG&E's contributions to your account because the RMSA has no cash value.
- Only PG&E can credit your RMSA with contributions; you may not contribute to your account.
- You forfeit your unused RMSA balance when you die. Your enrolled surviving spouse or registered domestic partner's RMSA will continue to help pay for his or her PG&E-sponsored retiree medical coverage until the account is depleted or until your spouse or registered domestic partner becomes eligible for Medicare, remarries or enters into a registered domestic partnership, becomes eligible for other employer-sponsored medical coverage, or chooses to decline PG&E-sponsored medical coverage.
- Your spouse or registered domestic partner's RMSA ends if you and your spouse divorce (or your domestic partnership is terminated) or if your spouse or registered domestic partner dies.
- If you marry, remarry or enter into a registered domestic partnership after you retire, your new spouse or registered domestic partner will not get a RMSA. In addition, your new spouse or registered domestic partner cannot use any remaining balance in a RMSA that belonged to your previous spouse or registered domestic partner.

Building Your RMSA While Employed at PG&E

The total value of your RMSA is within your control — the longer you work, the more you'll have when you retire. How much your account is worth when you retire depends on your age and years of service. The more years of service you have and the older you are, the higher the value of your RMSA. Although this program began in 2011, if you retiree in 2011 or later, your account value will be based on your total years of service.

Here's how the RMSA can grow the longer you work at PG&E.

Your Account — PG&E Contributes:	Your Spouse or Registered Domestic Partner's Account* — PG&E Contributes
$5,000 a year to your account for each year you're employed by PG&E, starting when you reach age 45 (or later if hired after age 45). Any full calendar year you were not employed by PG&E will be excluded from the $5,000 allocation.	$5,000 a year to your spouse or registered domestic partner's account for each year you're employed by PG&E, starting when you reach age 45 (or later if hired after age 45). Any full calendar year you were not employed by PG&E will be excluded from the $5,000 allocation.
Additional $1,000 a year to your account for each year of credited service beyond 15 years (including credited service before age 45) — credited at retirement.	Not applicable

Your Account — PG&E Contributes:	Your Spouse or Registered Domestic Partner's Account* — PG&E Contributes
Up to an additional lump sum of $7,500 to your account based on your years of credited service, prorated from 10 to 25 years of service — credited at retirement (equivalent to the Retiree Premium Offset Account).	Not applicable
4.5% interest to your account compounded annually beginning at the end of the year in which you reach age 46.	4.5% interest to your spouse or registered domestic partner's account compounded annually beginning at the end of the year in which you reach age 46.

* For your spouse or registered domestic partner to be eligible for the RMSA, you must be married or in a registered domestic partnership on your retirement date.

RMSA Example

PG&E will credit interest on the existing RMSA balances for you and your spouse or registered domestic partner starting at the end of the year in which you reach age 46 and continuing until you die. This credited interest is intended to help keep up with or offset medical inflation.

Here's an example of how credits and interest can add up under the RMSA.

Joe was born June 1, 1951, and was hired by PG&E June 1, 1981. He reached age 45 June 1, 1996, and retires June 1, 2013 at age 62. Joe's wife Jane was born November 1, 1953. This example assumes:

- Joe is credited with the full, $5,000 annual RMSA allotment at the end of the year in which he reaches age 45 (there is no proration for mid-year birthdates). Jane also receives a $5,000 credit for her RMSA.
- Joe is credited with another $5,000 for each year he's employed by PG&E until he retires — including the year in which he works his last day. Jane also receives a $5,000 credit for each year of Joe's PG&E employment.
- 4.5% interest is credited to each of their accounts at the end of each year, starting when Joe reaches age 46.
- Joe is credited with a maximum lump-sum allotment of $7,500 at retirement. Jane does not receive this credit.
- An additional $1,000 per year of credited service beyond 15 years is credited to Joe's account at retirement. Jane does not receive these credits.
- Joe and Jane both enroll for PG&E-sponsored retiree medical coverage at the same time. Their RMSAs also begin paying for a portion of their coverage costs at the same time.

Year	Joe's Years of Service (YOS)	4.5% Interest	New Allocation	Joe's Balance
12/31/1996	15		$5,000	$5,000.00
12/31/1997		$225.00		$5,225.00
12/31/1997	16		$5,000	$10,225.00
12/31/1998		$460.13		$10,685.13
12/31/1998	17		$5,000	$15,685.13
12/31/1999		$705.83		$16,390.96
12/31/1999	18		$5,000	$21,390.96
12/31/2000		$962.59		$22,353.55
12/31/2000	19		$5,000	$27,353.55
12/31/2001		$1,230.91		$28,584.46
12/31/2001	20		$5,000	$33,584.46
12/31/2002		$1,511.30		$35,095.76
12/31/2002	21		$5,000	$40,095.76
12/31/2003		$1,804.31		$41,900.07
12/31/2003	22		$5,000	$46,900.07
12/31/2004		$2,110.50		$49,010.57
12/31/2004	23		$5,000	$54,010.57
12/31/2005		$2,430.48		$56,441.05
12/31/2005	24		$5,000	$61,441.05
12/31/2006		$2,764.85		$64,205.90
12/31/2006	25		$5,000	$69,205.90
12/31/2007		$3,114.27		$72.320.17
12/31/2007	26		$5,000	$77,320.17
12/31/2008		$3,479.41		$80,779.58
12/31/2008	27		$5,000	$85,799.58
12/31/2009		$3,860.98		$89,660.56
12/31/2009	28		$5,000	$94,660.56
12/31/2010		$4,259.72		$98,920.29
12/31/2010	29		$5,000	$103,920.29
12/31/2011		$4,676.41		$108,596.70
12/31/2011	30		$5,000	$113,596.70
12/31/2012		$5,111.85		$118,708.55
12/31/2012	31		$5,000	$123,708.55

Year	Joe's Years of Service (YOS)	4.5% Interest	New Allocation	Joe's Balance
6/1/2013 **Joe retires**			$5,000	$128,708.55
Allotment for over 25 years of service			$7,500	$136,208.55
Additional $1,000/years of service > 15 YOS			$17,000	$153,208.55
Joe's beginning account balance at retirement				**$153,208.55**

By the time he retires in 2013, Joe has a RMSA balance of $153,208.55 to use for his retiree medical premiums until the account is depleted. In this example, Joe uses $5,000 of his RMSA in 2013, the year he retires:

Year	Joe's Years of Service (YOS)	4.5% Interest	Drawdown	Joe's Balance
12/31/2013			<$5,000>*	$148,208.55
Interest		$6,669.38		**$154,877.93**

* Drawdown figure is for example only and does not represent an actual projection.

In this case, even though Joe used $5,000 from his account in 2013, his account is worth more at the end of 2013 than it was on his retirement date — $154,877.93 on December 31, 2013, compared to $153,208.55 on June 1, 2013. That's because Joe's RMSA helped pay for seven months of retiree medical premiums during his first year of retirement, and at the same time, PG&E continued to credit Joe's account with annual interest to help counterbalance rising medical premium costs.

Jane's RMSA

Jane's initial RMSA balance will be $128,708.55, equal to Joe's $5,000 annual allotment and accrued interest through 2012, plus the final $5,000 allotted on Joe's retirement date. In this example, Jane spends $5,000 of her RMSA in 2013, the year Joe retires:

Year	Joe's Years of Service (YOS)	4.5% Interest	Drawdown	Joe's Balance
12/31/2012 (year before Joe retires)	31			$123,708.55
6/1/2013 (Joe retires) **2013 Allotment: $5,000**				$128,708.55
Jane's beginning account balance when Joe retires				**$128,708.55**
12/31/2013			<$5,000>*	$123,708.55
Interest		$5,566.88		**$129,275.43**

* Drawdown figure is for example only and does not represent an actual projection.

Using Your RMSA Balance During Retirement

Each year, the RMSA will pay a monthly percentage of your retiree medical premium costs until your account is depleted. At that point, you pay 100% of the premium cost. The percentage the RMSA will pay depends on what year it is.

In 2014, the RMSA will pay 59% of the cost of non-Medicare retiree medical coverage and 30% of the cost of Medicare retiree medical coverage.

The percentage the RMSA will pay for non-Medicare retirees decreases over the next few years until 2016, when it will remain at 55%. Beginning in 2014, it will remain at 30% for non-Medicare retirees.

The RMSA payment percentage will stay at these levels in future years.

Although the payment percentage initially decreases, the actual dollar amount paid by the RMSA is likely to increase as medical inflation increases.

Here's how the payment percentage decreases over time:

Year	Non-Medicare Retirees and Spouses/Registered Domestic Partners	Medicare Retirees and Spouses/Registered Domestic Partners
	The RMSA will pay this percentage of retiree medical premiums:	
2014	59%	30%
2015	57%	30%
2016	55%	30%
2017	55%	30%
2018	55%	30%

You will be responsible for paying the balance of the monthly premium after your RMSA has been applied. For example, let's say you retire in 2014 and you and your spouse are not on Medicare. You elect the Network Access Plan (NAP) for you and your spouse:

If the total monthly premium for 2014 is:	$2,513.89
Your RMSA will pay this amount each month (59% of the premium):	$1,483.20
You will pay this amount out of pocket each month:	$1,030.69

To estimate how much you and PG&E may pay for your retiree medical coverage when you plan to retire, access the Retiree Medical Estimator by logging onto the PG&E Pension Center website at https://www.pgepensioncenter.com on the Internet or go to PG&E@Work for Me - My Retirement on the intranet. From the Home page, click on "My Benefits" to find the Estimate tools.

For additional information about the Retiree Medical Plan, see the *Summary of Benefits Handbook for Retirees and Surviving Dependents* on the www.mypgebenefits.com website.

If Both You and Your Spouse are PG&E Employees

An employee can only have one RMSA. You can have either a retiree RMSA or a spousal RMSA, but not both:

- **If you're working and your spouse is retired,** your spouse can be covered as a dependent under your active employee plan and defer using his or her PG&E-sponsored retiree medical coverage until you retire. Typically, this is the most cost effective choice. Your spouse's RMSA will not start paying benefits until your spouse enrolls for retiree medical coverage.
- **When you retire and you both need to start using PG&E-sponsored retiree medical coverage,** you'll have a choice:

- **You each can choose to have your own, individual retiree RMSAs.** In this case, you each would need to elect your own retiree medical plan coverage as primary retirees. Neither you nor your spouse would be enrolled as dependents under the other's retiree medical plan. If you each choose your own retiree RMSAs, then your separate RMSA balances will be calculated based on each of your individual employment records.

  OR

- **One of you can make a one-time, irrevocable election to receive a spousal RMSA instead of a retiree RMSA.** Whoever elects the spousal RMSA will be covered as a dependent under the primary retiree's medical plan. If the primary retiree dies, the dependent spouse with the spousal RMSA will be subject to the provisions applicable to surviving spouses.

- **If one of you elects a spousal RMSA instead of a separate retiree RMSA,** then the spousal RMSA will be subject to the rules governing all other spousal RMSAs.

  Your spouse or registered domestic partner's RMSA will end when his or her account is depleted. In addition, your spouse or registered domestic partner's RMSA will end if you divorce or terminate your registered domestic partnership, or after your death, when he or she:

  - Becomes eligible for Medicare;
  - Remarries or enters into a registered domestic partnership;
  - Becomes eligible for other employer-sponsored medical coverage; or
  - Chooses to decline PG&E-sponsored medical coverage.

  PG&E will continue to credit the account with 4.5% annual interest until the account ends. Eligible spouses and registered domestic partners with Medicare coverage must pay the full cost of PG&E-sponsored medical coverage for themselves and for their enrolled children.

Postretirement Life Insurance

You are eligible for Postretirement Life Insurance coverage if you retire under the Company's Retirement Plan after age 55. You do not need to enroll for coverage. Coverage is automatic if you meet the eligibility requirements. The Company pays the full cost for your coverage.

For more details about Life Insurance, including eligibility, claims and appeals, converting coverage to an individual policy, and administrative information, see the *Life and Accident Insurance Plans* section of this handbook. For more details about Postretirement Life Insurance, see *Postretirement Life and Accident Insurance Plans* in the Summary of Benefits Handbook for Retirees and Surviving Dependents.

Amount of Coverage

The basic amount of Postretirement Life Insurance coverage for retirees is $8,000.

Time Off and Leaves

Each year, you are able to earn paid vacation. In addition, the Company observes 10 paid holidays, and you receive three floating holidays.

Other types of time off policies are also described in this section, including time off for:

- Leaves of Absence
- Jury Duty
- Funerals
- Adoption
- Voting
- Family School Partnership Act (FSPA)
- Victims of Domestic Violence, Sexual Assault, or Stalking Act (VDVA)
- Victims of Crime Act (VCA)
- Victims of Crime to Testify
- Civil Air Patrol Leave
- Emergency Duty Leave and Volunteer Firefighter Training
- San Francisco Family Friendly Workplace Ordinance (SF FFWO)

Who's Not Eligible

You are not entitled to Time Off benefits, as described in this section, if you are a contract or agency worker, a hiring hall employee, or a retiree. Hiring Hall employees may be entitled to time off under the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), or other state statutes if they meet the criteria described under "Leaves of Absence" on page 439. For additional information, please refer to the *Sick Leave & Disability* section.

Additional Information

In addition to the information in this section, there is also important information about your benefits in other parts of this Handbook. Be sure to review the *About this Handbook* section, the *Benefits at a -Glance* section, the *What If...* section, and the *Rules, Regulations & Administrative Information* section.

In This Section

Time Off and Leaves at a Glance

Vacation	▪ Eligible Company employees earn paid vacation days under the Vacation Program. ▪ Vacation is earned "as you go," based on straight time hours worked according to your length of service. ▪ You receive an additional five service anniversary days (40 hours) in the year in which you complete 5 years of service and in each fifth calendar year thereafter. ▪ For additional information, see the *Time Off* section.
Paid Holidays	▪ You are eligible to receive holiday pay after completing six months of employment and attaining regular status. ▪ The Company recognizes 10 public holidays and three floating holidays a year with pay. The 10 recognized holidays are: ▫ New Year's Day ▫ Martin Luther King, Jr. Day ▫ Presidents' Day ▫ Memorial Day ▫ Independence Day ▫ Labor Day ▫ Veterans' Day ▫ Thanksgiving Day ▫ Friday after Thanksgiving ▫ Christmas Day
Leaves of Absence	▪ The Leave of Absence policy enables you to take time off for medical reasons (for you or an eligible family member), to care for and bond with a new child, for military duty, or for other personal situations that are urgent and/or substantial.
Other Time Off	▪ You may be eligible for paid time off for jury duty, funerals, adoption, and voting. ▪ You may also be eligible for time off under the Family School Partnership Act (FSPA), the Victims of Domestic Violence, Sexual Assault, or Stalking Act (VDVA), the Victims of Crime Act (VCA), Victims of Crime to Testify, Civil Air Patrol Leave, Emergency Duty Leave and Volunteer Firefighter Training or the San Francisco Family Friendly Workplace Ordinance (SF FFWO).

Vacation Program

The Vacation Program described in this section applies to employees of the Company and its subsidiary and affiliated companies that participate in the Vacation program.

Earning Vacation

As a union-represented employee, you begin earning vacation upon your first day of work; new employees become eligible to take vacation upon attaining regular status.

The amount of vacation you earn is based on your length of service with the Company. Upon hire, you are eligible to earn vacation up to 80 hours per calendar year. Regardless of the month in which you are hired, you will begin earning vacation at the time of hire.

You earn vacation time each pay period. The vacation awarded in a pay period is calculated by multiplying your paid straight time hours by the appropriate vacation accrual rate for your years of service. All paid straight time qualifies for vacation accrual. Paid straight time (as defined here) includes, but is not limited to, vacation, sick leave and sick relative leave, paid holidays, training, funeral leave, rest periods, time off with permission with pay,

Workers' Compensation of less than 880 cumulative hours for full-time employees in a calendar year, unpaid leaves of absence of less than 240 cumulative hours for full-time employees in a calendar year, and leaves of absence with pay. If you exceed the cumulative hours of absence in a calendar year, you will not earn additional time until you return to work.

Part-time employees should refer to their bargaining agreement for information on vacation accrual.

Your accrual rate increases each January 1 of your 5th, 15th, 21st, and 29th anniversary year of employment, as shown in the following table. For example: If your 5th anniversary is attained at any time during the year, your accrual rate beginning January 1 of that year will be at the 5–14 years of service level, which is 120 hours per year.

Earned Annual Vacation		
If your service anniversary year is	**Number of Vacation Days (Hours) You Earn**	**Total Maximum Vacation Allowance**
Up to 1 Year	1 – 10 days (0 to 80 hours)	N/A
1 –4 Years	10 days / 80 hours	20 days / 160 hours
5–14 Years	15 days / 120 hours	30 days / 240 hours
15–20 Years	20 days / 160 hours	40 days / 320 hours
21–28 Years	25 days / 200 hours	50 days / 400 hours
29 or more Years	30 days / 240 hours	60 days / 480 hours

Earned vacation hours are shown as whole hours on each pay statement. Fractions of hours are accumulated and carried over to the next pay period. When the fractional hours accumulate to equal one hour, that hour is awarded and reflected on your pay statement and any new fractional hours will be stored and carried over to the next pay period.

Transfers from or to a Union-Represented Position

If you transfer from a Management or Administrative & Technical position to a union-represented position during the year, at the time of transfer you will begin earning vacation at the accrual rate for a union-represented position (see the "Earned Annual Vacation" table under "Earning Vacation" on page 433).

If you return to a Management or Administrative & Technical position during the year, you will begin earning vacation equal to the accrual rate for your Management or Administrative & Technical position at the time of transfer.

Transfers from a Paid-Time Off (PTO) Program to a Vacation Program

If you transfer from the PTO Program offered to employees of PG&E Corporation, PG&E Corporation Support Services, Inc. or PG&E Corporation Support Services II, Inc. to the vacation program offered to Company employees, you will begin earning vacation at the time of transfer at the accrual rate for the Company's vacation program described in this section. Your years of service recognized by the PTO program also will be recognized in determining vacation accruals provided you transfer directly between the companies with no break in service. Any unused PTO will be transferred and converted to vacation, and unused floating holiday and paid holiday balances will be transferred in-kind. If you have a frozen Sick Leave Bank it will be transferred and converted to sick leave.

Effects of Absence on Vacation Accrual

Vacation accrues based on paid straight-time hours worked. This includes most hours of paid leave such as paid sick or sick relative leave, vacation, Vacation Buy Days, paid holidays, floating holidays, training, etc., as well as Workers' Compensation of less than 880 cumulative hours for full-time employees in a calendar year, unpaid leaves of absence of less than 240 cumulative hours for full-time employees in a calendar year, and leaves of absence with pay.

Vacation does not accrue for absences due to:

- Unpaid leave of absence of 240 cumulative hours or more in a calendar year;
- Layoff;
- Long-Term Disability; or
- Workers' Compensation of 880 cumulative hours or more in a calendar year.

Part-time employees should refer to their bargaining agreement for information on how absence affects vacation accrual.

Employees on Alternate Work Schedules

If you work an alternate work schedule (9/80 or 4/10), your used vacation is recorded and charged against your vacation accrual according to your regularly-scheduled workweek. For example, if an employee on a 4/10 work schedule takes vacation on a scheduled workday, 10 hours of vacation will be recorded for that day.

Illness While on Vacation

If you should become sick or disabled while on vacation, you may request, as soon as practicable, that your vacation be changed to sick leave for those days you were sick. However, you must submit satisfactory medical evidence to your supervisor within 10 working days of your return to work. Qualifying reasons for requesting the change would be if you were hospitalized for one or more days or were ordered to bed rest by your doctor.

If your illness or disability is covered under any of the leave of absence provisions, a leave of absence must be initiated for job protection through the Company's Leave Administrator and a completed Health Care Provider Certification must be submitted for approval. You can reach the Company's Leave Administrator at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 866-369-7582.

Service Anniversary Days

You receive an additional five service anniversary days (40 hours) in the year in which you complete five years of service and in each fifth calendar year thereafter.

To qualify for service anniversary days, you must:

- Be on the active payroll (including paid sick leave, vacation, Workers' Compensation of less than 880 cumulative hours in a calendar year, or leave of absence with pay),
- Not be receiving benefits under the Company's Long-Term Disability plan, and
- Work in the year that service anniversary days are awarded.

Your service anniversary days will be available to you in the year in which you meet the service requirements provided you have worked one day in that year.

If you terminate prior to the year in which you would have received service anniversary days, you are not eligible for cash payment of prorated service anniversary days.

Service anniversary days do not apply to your maximum vacation allowance.

Any service anniversary days not used in the calendar year in which they are awarded will be deferred to the next year.

Part-Time and Intermittent Employees

Union-represented intermittent employees are not eligible for service anniversary vacation. If you are a part-time employee, refer to your particular bargaining agreement for provisions regarding eligibility for service anniversary vacation.

How to Schedule or Defer Your Vacation

Scheduling Your Vacation

Please refer to your particular bargaining agreement for provisions regarding scheduling vacation.

Also, when you take vacation, service anniversary and sick leave bonus vacation days will be deducted first (if applicable) followed by current and deferred vacation.

Deferring Your Vacation

You are encouraged to take vacation each year in order to maintain your physical and emotional health. Nevertheless, there may be times when it is necessary for you to defer some of your vacation days to the following year.

Unused vacation and floating holidays will be automatically deferred; however, the total amount of vacation accrual (current and deferred) you may have on record as of December 31 of each year is limited to two times your current annual accrual rate. If your deferred and current vacation accrual exceeds your total maximum vacation allowance as of December 31, all excess hours above the maximum allowance will be paid out to you the following February. (See "Excess Vacation Payout" on page 436).

Service anniversary days (See "Service Anniversary Days" on page 435) will not count towards the maximum vacation allowance in the year awarded.

To avoid a payout of your vacation, you should make sure that current and deferred vacation (including any unused Floating Holiday time that converts to vacation), when combined, will not exceed your total maximum vacation allowance. For additional information see "Floating Holidays" on page 438.

Work In-Lieu of Vacation

If you are requested to forego any part of your vacation, the Company will pay for the time worked and, in addition, will pay a vacation pay allowance, provided, however, that in no event will you be permitted at your option to forego vacation for the purpose of receiving vacation pay allowance in addition to pay for time worked. Time worked in-lieu of time off for vacation will not be considered overtime as such but will be compensated at the rates of pay applicable to the work performed.

Excess Vacation Payout

If your vacation balance exceeds the maximum vacation allowance, a one-time annual payout will be made in February of each year for excess vacation as of December 31 of the prior year. The excess vacation payout will be calculated using your base rate of pay, less tax withholdings.

Voluntary Vacation Transfer

You may request, through your department, to sell your vacation days in order to give the proceeds of the sale to the following:

- a fellow employee or a member of his or her family experiencing a medical emergency; or
- yourself or a member of your family experiencing a medical emergency.

A letter of agreement between the Company and Union is required before any employee can elect to sell vacation for another employee's medical emergency.

You must complete a "Vacation Sale for Medical Emergency" form (62-0494) to initiate your request. The form is available from the **Human Resources Forms** section of the PG&E@Work intranet or by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll free at 800-788-2363.

You are responsible for the taxes on a voluntary vacation transfer. The Payroll Department will issue the check. The donor will not receive a check but will receive a letter of explanation and a receipt showing the gross amount of their vacation donation and taxes. The net amount of the check will be transferred to the recipient. The recipient will receive a single check payable to him/her for the combined amount of all the vacation donations and a list of the donors. Refer to the Vacation section of your bargaining agreement for more details on Voluntary Vacation Transfer rules.

Vacation Pay Upon Termination

If you terminate employment with the Company (including resignation, retirement or death) or are laid off, you will be paid any earned but unused vacation including any deferred or service anniversary days.

Vacation pay is computed at the base rate of pay applicable to your regular position at the time you terminate. For vacation payout purposes, fractional hours will be rounded to the next highest full hour.

Re-employment with the Company

If you terminate and are later re-employed, you do not receive vacation credit for prior service. Vacation, including Service Anniversary Vacation, will be earned in the same manner as for new employees.

Employees who have been laid off and who are later re-employed may receive vacation credit for prior service, depending upon the length of absence. Refer to the Vacation section of your bargaining agreement for applicable rules.

Paid Holidays

You are eligible to receive holiday pay after completing six months of employment and attaining regular status. In general, once you are eligible, you must be on a "paid" status to be eligible for holiday pay (for example, actively working or on sick leave, vacation,, or time off with permission, with pay before and/or after the holiday).

The Company recognizes 10 public holidays and three floating holidays a year with pay. The 10 recognized public holidays are:

New Year's Day	January 1
Martin Luther King, Jr. Day	Third Monday in January
Presidents' Day	Third Monday in February
Memorial Day	Last Monday in May
Independence Day	July 4
Labor Day	First Monday in September
Veterans' Day	November 11
Thanksgiving Day	Fourth Thursday in November
Friday after Thanksgiving	Friday after Thanksgiving
Christmas Day	December 25

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation. The plans and benefits described in this section are also applicable to employees of designated subsidiaries and affiliates, but only to the extent that such entities are participating employers with respect to the described plans or programs and such employees meet the eligibility requirements of the plans or programs.

Regular-status part-time employees are eligible to receive prorated Paid Holiday based on their work schedule. Intermittent employees who are regularly scheduled to work on a Company holiday are eligible to receive pay for the number of hours they are scheduled to work on that day (unless the employee is off work without permission). The three floating holidays are to be used on days on which employees are scheduled to work.

Please refer to the Alternative Work Schedule Standard for additional details on Company Holidays for employees on alternate work schedules.

When a Holiday Falls on a Weekend or Non-Workday

When a holiday falls on a Sunday, it is generally observed on the following Monday.

If a holiday falls on a non-workday other than Sunday, full-time employees will be allocated eight paid holiday hours immediately before the holiday has occurred. Part-time employees will receive a prorated Paid Holiday based on their work schedule. These paid holiday hours will be automatically used the next time the employee takes a day off. If the paid holiday hours are not used in the current year, they may be deferred to the following year. By agreement between the employee and the Company, an employee may elect within ten workdays after the holiday to receive the equivalent in straight-time pay instead of the paid holiday hours.

Intermittent employees will receive pay for non-workday holidays only if they are regularly scheduled to work on that day. The amount of payment an employee receives is equal to what the employee would have earned on that day had it not been a holiday.

Work Performed on a Holiday

If you are required to work on a holiday (regardless of whether it is on a normal workday or regular day off), you will receive overtime for the hours worked and holiday pay. You may request to have the paid holiday hours remain in your paid holiday account for later use rather than receive holiday pay.

The following explains holiday pay treatment:

Workday	Pay
You do not work	You receive holiday pay.
You work during regular work hours	You receive overtime for hours worked and holiday pay*
You work outside of regularly scheduled hours	You receive overtime for hours worked and holiday pay.
Non-Workday	**Pay**
You do not work	You receive 8 paid holiday hours in paid holiday account.
You work	You receive overtime for hours worked and holiday pay*.

* Rather than receive holiday pay, you may complete the Holiday Option form to have the holiday hours remain in your paid holiday account for later use.

Floating Holidays

You will automatically be allocated 24 hours of floating holiday time on January 1 of each year in which you have worked (including years in which you are not actively at work but receiving pay while on sick leave, vacation, on Workers' Compensation for less than 880 cumulative hours in a calendar year, unpaid leave of absence of less than 240 hours in a calendar year, or a paid leave of absence).

Request for use of Floating Holidays is limited to days that the employee is scheduled to work.

Unused floating holiday hours will convert to deferred vacation in January of the following calendar year. If your floating holidays convert and you exceed your total maximum vacation allowance on December 31 of that year, the excess vacation hours will be paid out by the end of February of the following year.

See "Excess Vacation Payout" and "How to Schedule or Defer Your Vacation" under "Vacation Program" on page 433.

Unused Floating Holiday Pay Upon Termination

If you terminate your employment with the Company or are laid off, you will be paid for all unused floating holiday hours at your base rate of pay at the time of your termination.

Alternate Work Schedules

Please refer to your union agreement for details on floating holiday pay for employees on alternate work schedules.

Part-Time Employees

If you are a part-time employee, you may use floating holiday hours on days that you are regularly scheduled to work. The Company will pay part-time employees 8 hours whenever they use a floating holiday. This is regardless of the number of hours the part-time employee is scheduled to work on the day the floating holiday is taken. Example: Employee works 4 hours a day, Floating Holiday will equal 8 hours of floating holiday pay.

Leaves of Absence

The Leave of Absence policy enables you to take time off for medical reasons (for you or an eligible family member), to care for and bond with a new child, for military duty, or for other personal situations that are urgent and substantial. Some of the leaves are legally-mandated by federal and/or state laws, such as the Family and Medical Leave Act (FMLA), the California Family Rights Act (CFRA), the Pregnancy Disability Leave Act (PDL), California Organ and Bone Marrow Donor Leave, the Fair Employment and Housing Act (FEHA), and the Uniformed Services Employment and Re-Employment Rights Act (USERRA). These leaves carry certain restrictions, employee eligibility criteria, limitations and obligations. Because most of our employees reside or work in the State of California, this Leaves of Absence section refers to California laws, when applicable. If a different state law applies, given an employee's state of residence or work location, the Company will comply with that state's requirements. See "Determination for Eligibility and Entitlements under FMLA/CFRA Leave" on page 440.

Impact on Benefits

For additional information about your benefits during a leave of absence, see "I Take an Unpaid Leave of Absence" in the *What If…* section.

Generally, federal- and state-mandated leave laws do not provide for paid time during a leave of absence. However, the Company may require the use of sick leave or family sick leave during certain types of leaves of absence. In addition, you may elect to use vacation, or floating holidays, if applicable. Company-specific leaves are unpaid.

Please note that while receiving job protection under FMLA/CFRA/PDL or a Company leave you have no greater right to reinstatement or to other benefits and conditions of employment than if you had been continuously employed during the leave period. Job protection offered by FMLA/CFRA/PDL and the Company leaves entitle you to the same or a comparable position upon your return to work if such a position still exists. If your position is eliminated during your absence you will be treated as if you were at work and may be afforded the Company's Workforce Management Benefits.

Foreseeable leaves must be requested through your supervisor and the Company's Leave Administrator 30 days in advance of the date your leave commences. Unforeseeable leaves must be requested as soon as your need for leave is known (as soon as practicable). If sufficient notice is not provided, your leave commencement date may be delayed or your leave may be denied.

See "I Take an Unpaid Leave of Absence" in the *What If…* section for additional information regarding benefits during an unpaid leave of absence.

The following information is a summary only. You can access more information from the **Leaves of Absence** section of the PG&E@Work intranet or by contacting the Company's Leave Administrator at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 866-369-7582.

Determination for Eligibility and Entitlements under FMLA/CFRA Leave

Eligibility for, and entitlement to, FMLA/CFRA Leave is complex. The reason for leave is how you determine whether or not the FMLA/CFRA Leave is a Medical Leave of Absence or a Personal Leave of Absence. The following information is provided to help you to better understand the requirements. See "Medical Leaves of Absence" on page 441 and "Personal Leaves of Absence" on page 444.

Eligibility

You are eligible for FMLA/CFRA Leave if you meet all of the following criteria:

- You have worked for the Company for at least 12 months (cumulative);
- You have worked at least 1,250 hours in the 12 months that immediately precede the date your leave commences. Only actual hours worked are used in this calculation, including straight and overtime hours (absences whether paid or unpaid are not used in this calculation); and
- You have not exhausted the 12 weeks of FMLA/CFRA entitlement in a rolling 12-month period, as described under "Entitlement," below.

A period of absence for military service counts as time worked toward your eligibility for leave under FMLA/CFRA.

If you are a Hiring Hall employee who has met the eligibility criteria, you are eligible for leave entitlements under FMLA/CFRA.

Entitlement

The Company uses a rolling 12-month period measured backward from the date you use any FMLA/CFRA leave to determine your available 12-week entitlement.

Every rolling 12-month period, you may be eligible for up to a total of 12 weeks of FMLA/CFRA leave time for the following reasons:

- For the birth of a child, or to bond with a newborn, newly-adopted, or newly-placed foster child (leave must be taken within 12 months of the birth, adoption or foster placement);
- To care for a spouse, registered domestic partner (CFRA only), parent or child (including the child of a registered domestic partner) with a serious health condition; and/or
- For your own "serious health condition," as defined by the laws.
  - Under California's Fair Employment and Housing Act (FEHA), employees **who are disabled due to pregnancy** are eligible for up to four months of pregnancy disability leave, if medically necessary as determined by a physician, regardless of any other FMLA/CFRA leave they have already taken during the previous 12-month period.
- Because of any qualifying exigency arising out of the fact that an employee's spouse, son, daughter, or parent who is a member of the Armed Forces (including National Guard and Reserves) and who is on covered active duty or has been notified of an impending call or order to covered active duty (FMLA only).
- **FMLA Military Caregiver Leave** — an eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member/veteran shall be entitled to a total of 26 workweeks of leave during a single 12-month period to care for the service member/veteran. The leave described in this paragraph shall only be available during a single 12-month period (FMLA only). Please see "Personal Leaves of Absence" on page 444 for more information on this leave.

When you take time off for any of the FMLA/CFRA reasons listed above, the time off is "subtracted" from your 12-week entitlement during that 12-month period (taking time off for a pregnancy related condition, to care for an injured service member who is not covered under CFRA or exigency leave due to a call to covered active duty will not be "subtracted" from your 12-week CFRA entitlement). Time off under FMLA/CFRA may be taken on a continual, intermittent or reduced schedule basis as appropriate (please see "Personal Leaves of Absence" on page 444 for restrictions when taking time off intermittently for child bonding reasons).

Qualifying for an FMLA/CFRA leave is dependent upon how much total FMLA/CFRA leave time you have already taken in the previous 12 rolling months for any of these combined reasons. You need to meet the eligibility requirements for each new leave requested.

- If you have not taken any FMLA/CFRA leave time in the previous 12 months for bonding with a newborn, newly-adopted or newly-placed foster child; the care of a spouse, registered domestic partner, parent or child (including the child of a registered domestic partner) with a serious health condition; for a qualifying exigency due to a spouse, son or daughter, or parent who is on covered active duty or has been notified of a call to covered active duty in the Armed Forces; or for your own serious health condition (other than pregnancy), you may apply for up to 12 weeks of FMLA/CFRA leave for any of the reasons listed.
- If you have taken less than 12 weeks of FMLA/CFRA leave in the previous 12 months for any of the reasons listed, you may apply for the balance of your 12-week FMLA/CFRA leave.
- If you have already taken your full 12 weeks of FMLA/CFRA leave in the previous 12 months, you are not entitled under FMLA/CFRA to take further FMLA/CFRA leave for the reasons listed. However, you may be eligible for a medical or personal leave under the Company-provided leaves (see "Medical Leaves of Absence" on page 441 and "Personal Leaves of Absence" on page 444). Once you have regained available FMLA/CFRA entitlements, you may apply for additional FMLA/CFRA leave (you will need to meet the hours worked requirements in order to be eligible for another FMLA/CFRA leave).
- If you take a leave for medical or personal reasons which meet the requirements and definitions of FMLA/CFRA, your leave will be counted against your 12-week FMLA/CFRA entitlement.
- During the single 12-month period as described in the FMLA Military Caregiver Leave, you may be eligible to take a combined total of 26 workweeks of leave for this reason and any of the reasons listed.

Types of Leave

There are three types of leaves at the Company: Medical, Personal, and Military. Each type of leave has specific provisions regarding the conditions under which it may be granted. In addition, each type of leave may affect your benefits, employment status or other issues. Leaves must be reported 30 days in advance if the leave is foreseeable; otherwise, it must be reported as soon as the need for leave is known.

The different types of leaves which may be authorized are listed below. Each type of leave is further explained in this section.

Medical Leaves of Absence

You may request an FMLA/CFRA Medical Leave as provided for by the Family and Medical Leave Act and/or California Family Rights Act if you have a "serious health condition," as defined by the laws (including industrial injuries that meet this definition). You may request a Pregnancy Disability Leave (PDL) as provided for under the Fair Employment and Housing Act (FEHA) or a California Organ and Bone Marrow Donor Leave. A Company Medical Leave of Absence without pay may be granted to eligible regular-status employees who are unable to work for more than 10 consecutive workdays, due to illness or injury off the job (which may include certain injuries/illnesses related to settled/closed Workers' Compensation claims).

You have the right to elect to continue your existing Company health care plan coverage during your medical leave of absence. See "Benefit Coverage for Each Leave Type" under "You Take an Unpaid Leave of Absence" in the *What If...*section for additional information.

You can access more information from the **Leaves of Absence** section of the PG&E@Work intranet or by contacting the Company's Leave Administrator at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 866-369-7582.

If you are on a medical leave of absence or are an employee with a disability, you can request a reasonable accommodation (which may include additional time off) in order to perform the essential functions of your job to return from leave or remain at work. For more information on eligibility and how to obtain a request form, please refer to the **Reasonable Accommodations and the Interactive Process** section of the PGE@Work intranet or email the Stay-At-Work Team at HROpsInteractiveD@pge.com or see "Resources to Help You Stay at/Return to Work" in the *Sick Leave and Disability* section.

If you are a California employee

You may be eligible for State Disability Insurance (SDI) offered by the Employment Development Department of California (EDD) during your medical leave of absence. Company sick pay is required to be used first during a medical leave, except for pregnancy related leaves, and is in conflict with SDI benefits. The Company does not coordinate paid time with SDI. SDI does not provide job protection or return rights. There is a seven day waiting period that applies. Employees must file a claim with the EDD to receive benefits. EDD can be reached at www.edd.ca.gov or at 800-480-3287. The employer's address to use on the form is 1850 Gateway Blvd. 7th Floor, Concord, CA 94520

FMLA/CFRA Medical Leave

Pursuant to the FMLA and CFRA laws, if you are an eligible employee and have a qualifying event or condition and/or are unable to work for more than three consecutive calendar days **and** require continuing treatment due to your own "serious health condition," you may take up to 12 weeks of paid or unpaid FMLA/CFRA leave in a rolling 12-month period. If the leave is taken due to pregnancy disability, you are entitled to up to four months of medical leave while disabled due to pregnancy, pursuant to California's Fair Employment and Housing Act. This four-month leave is separate from any child care/bonding leave which is available pursuant to the FMLA or CFRA laws and/or Company leave policies. FMLA/CFRA may be used on a continual, intermittent, or reduced schedule basis, as medically necessary. Medical certification of a "serious health condition" is required. See "Eligibility" and "Entitlement" under "Determination for Eligibility and Entitlements under FMLA/CFRA Leave" on page 440 for more information about eligibility and entitlement limitations.

Available sick pay must be used and exhausted prior to being unpaid by the Company or requesting vacation or floating holidays (paid time other than sick pay is subject to your supervisor's approval), during a FMLA/CFRA medical leave. The use of paid time does not extend the maximum period of leave as provided for under FMLA/CFRA. You are not eligible to use paid time intermittently or on a reduced schedule when on a continual leave of absence. Unpaid continual FMLA/CFRA medical leave runs concurrently with a Company Medical Leave, if you are eligible. FMLA/CFRA medical leave runs concurrently with approved Workers' Compensation absences, when applicable.

The Company may require a second and third opinion for certification of your own serious health condition, and medical re-certification may be required when applicable. A release to return to work form is required for absences two weeks or longer, or as the condition merits. When released to return to work, you may generally return to your former or an equivalent position and work location.

A Leave of Absence must be initiated for job protection through the Company's Leave Administrator, and a completed Health Care Provider Certification must be submitted for approval. Thirty days' advance notice is required when the leave is "foreseeable."

Pregnancy Disability Leave (PDL)

The Pregnancy Disability Leave Act under the Fair Employment and Housing Act (FEHA) requires the Company to provide employees up to four months (equivalent to 88 work days for full-time employees) of paid or unpaid, job-protected leave, if medically necessary, for a disability on account of pregnancy, prenatal care, childbirth, or related medical conditions. FEHA also provides for an employee affected by pregnancy the ability to request a transfer to a less strenuous or hazardous position/duties if her health care provider certifies it is medically advisable to do so. There is no service requirement to be eligible for PDL (employee must work in California). PDL can be used on a continual, intermittent or reduced schedule basis, as medically necessary. Medical certification of disability or medically advisable transfer is required.

You may elect to use any available paid sick leave, vacation, or floating holidays (paid time other than sick pay is subject to your supervisor's approval). The use of paid time does not extend the maximum period of leave as provided for under PDL. You are not eligible to use paid time intermittently or on a reduced schedule when on a continual leave of absence. Unpaid continual PDL of more than 10 consecutive workdays runs concurrently with the Company Medical Leave, if you are eligible.

PDL runs concurrently with FMLA for pregnancy-related disability or consecutively with FMLA/CFRA for child-bonding purposes, if you are eligible and have not exhausted your FMLA/CFRA entitlement within the rolling 12-month period prior to your child bonding leave starting.

Medical re-certification may be required when applicable. A release to return to work form is required for absences two weeks or longer or as the condition merits. When released to return to work, you may generally return to your former or an equivalent position and work location.

A Leave of Absence must be initiated for job protection through the Company's Leave Administrator and a completed Health Care Provider Certification must be submitted for approval. Thirty days' advance notice is required when the leave is "foreseeable." If a transfer is needed, please refer to the **Reasonable Accommodations and the Interactive Process** section of the PGE@Work intranet to obtain a request form or email the Stay-At-Work Team at hropsinteractiveD@pge.com.

California Organ and Bone Marrow Donor Leave

If you have been employed by the Company at least 90 days immediately preceding the commencement to your leave, you are eligible for the Organ and Bone Marrow Donor Leave. Medical Certification that you are an organ or bone marrow donor and that there is a medical necessity for the donation of the organ or bone marrow is required. Leave may be taken in one or more periods. When released to return to work, you may generally return to your former or an equivalent position and work location.

Organ and Bone Marrow Donor Leave do not run concurrently with leave taken under the Family and Medical Leave Act (FMLA) or the California Family Rights Act (CFRA). However, you may be able to extend your leave of absence beyond the time period covered under the organ (30 days) and bone marrow (five days) provisions by requesting an extension under the FMLA, CFRA and/or the Company Medical Leave of Absence (MLOA).

The Leave of Absence must be initiated for job protection through the Company's Leave Administrator and a completed Medical Certification form must be submitted for approval. Thirty days' advance notice is required when the leave is "foreseeable."

Organ Donor Leave

You are eligible for up to 30 days of paid leave in a rolling 12-month period in order to donate an organ. If you have available sick and/or vacation pay, you are required to use up to two weeks of your available paid time first. Available sick pay must be used and exhausted prior to available vacation pay. If your organ donor leave extends beyond two weeks or you do not have two weeks of paid time available, the remaining portion of your 30 day leave will be paid by the Company.

The law provides for up to 30 days of **paid** organ donor leave. If your absence is longer than 30 days, normal company pay policies will apply beginning the 31st day through the remainder of your absence. For example, if you still have available sick pay after using your two weeks of sick time at the outset of the leave per Company policy, you will be required to use any additional sick pay time beginning day 31. Once your sick pay is exhausted, you may request to use available vacation pay/floating holiday pay (subject to your supervisor's approval) or be unpaid for the remainder of your leave.

Bone Marrow Donor Leave

You are eligible for up to five days of paid leave in a rolling 12-month period in order to donate bone marrow. If you have available sick and/or vacation pay, you are required to use up to five days of your available paid time first. Available sick pay must be used and exhausted prior to available vacation pay. If your available paid time is less than five days, the remaining portion of your five day leave will be paid by the Company.

The law provides for up to five days of **paid** bone marrow donor leave. If your absence is longer than five days, normal company pay policies will apply beginning the sixth day through the remainder of your absence. For example, if you still have available sick pay, you will be required to use available sick pay beginning day six. Once your sick pay is exhausted, you may request to use available vacation pay (subject to your supervisor approval) or be unpaid for the remainder of your leave.

Company Medical Leave (MLOA)

If you are a regular-status employee, you may be eligible for an unpaid Company Medical Leave due to illness and/or injury off the job (which may include certain injuries/illnesses related to settled/closed Workers' Compensation claims). For a MLOA which is not an FMLA/CFRA/PDL leave, a physician's statement defining your current work limitations and capabilities, the specific job functions you are unable to perform, your planned treatment and the estimated length of disability is required on the Medical Certification form (there needs to be sufficient medical information to support your requested medical leave). You must exhaust all of your paid sick leave prior to being eligible for a MLOA, with the exception of a Pregnancy Disability Leave. A MLOA is an unpaid absence of more than 10 consecutive workdays and cannot be taken on an intermittent basis or on a reduced schedule. MLOA may run concurrently with an unpaid, continual FMLA/CFRA/PDL leave.

The leave ends when you are released to return to work, with or without reasonable accommodations, or qualify for Long-Term Disability benefits. A MLOA may be granted for a period not in excess of six consecutive months. An extension may be granted for up to an additional six months if the circumstances warrant. The maximum length of an unpaid medical leave, including extensions, is 12 consecutive months in combination with all other leaves, excluding a military leave. You may be required to be examined by a panel physician during your leave and/or prior to your return to work. Medical re-certification may be required when applicable. A release to return to work form is required for absences two weeks or longer or as the condition merits. When released to return to work, you may generally return to your former or an equivalent position and work location. A request for MLOA may not be granted based on your history of overall unavailability and service to the Company. For example, if the granting of leave(s) has not proven effective in increasing your ability to return to work and/or remain at work, additional leave may not be granted.

If you fail to return immediately on the expiration of your approved MLOA, accept other employment while on a MLOA (with certain exceptions), or make an application for unemployment benefits while on a MLOA, you will no longer be considered on an approved MLOA and your employment with the Company will end. This leave will not be granted to cover a period of incarceration or if the purpose for which it is requested may lead to your resignation.

The Leave of Absence must be initiated through the Company's Leave Administrator and a completed Medical Certification form must be submitted for approval. Thirty days' advance notice is required when the leave is "foreseeable."

Personal Leaves of Absence

The Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) require employers to grant eligible employees up to 12 weeks of paid or unpaid leave within a rolling 12-month period for specified family-related reasons (or up to 26 weeks for the FMLA Military Caregiver Leave in a single 12-month period). The Company may grant additional leaves of absence without pay to eligible regular-status employees for qualifying reasons and service to the Company.

You have the right to elect to continue your existing Company health care plan coverage during your personal leave of absence; however, the amount you pay may increase depending on the duration of your personal leave. See "Benefit Coverage for Each Leave Type" under "Your Take an Unpaid Leave of Absence" in the *What If…*section for additional information.

You can access more information from the **Leaves of Absence** section of the PG&E@Work intranet or by contacting the Company's Leave Administrator at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 866-369-7582.

FMLA/CFRA Family Care Leave

The four types of FMLA/CFRA Family Care Leave are described in this section. See "Eligibility" and "Entitlement" under "Determination for Eligibility and Entitlements under FMLA/CFRA Leave" on page 440 for more information about eligibility and entitlement limitations.

Leave for the Birth of a Child and/or to Bond with a Newborn, Newly-Adopted or Newly-Placed Foster Child

If you need time off for the birth and/or to bond with a newborn child, a newly-adopted child or a newly-placed foster child (including a newborn child, a newly-adopted child or a newly-placed foster child of a registered domestic partner with whom you will stand in loco parentis), you may request up to 12 weeks of paid or unpaid FMLA/CFRA leave, to be completed within one year of the child's birth, adoption or foster placement.

You may elect to use any available vacation or floating holidays, subject to your supervisor's approval. You are not eligible to use sick pay during a bonding leave. There are certain exceptions that allow for the use of Family Sick Leave (FSL) at the onset of your Child Bonding Leave. Additional information regarding these exceptions can be found on the **Leaves of Absence** section of the PG&E@Work intranet. The use of paid time does not extend the maximum period of leave as provided for under FMLA/CFRA. You are not eligible to use paid time intermittently or on a reduced schedule when on a continual leave of absence. Unpaid continual FMLA/CFRA child-bonding leave more than 10 consecutive workdays runs concurrently with the Company Child Care/Bonding Leave, if you are eligible.

If You Are a California employee

You may be eligible for up to six weeks of Paid Family Leave Insurance (PFL) offered by the Employment Development Department of California (EDD) during your personal leave of absence. Family Sick pay is required to be used first during a leave to care for a family member, and is in conflict with PFL benefits. The Company does not coordinate paid time with PFL. PFL does not provide job protection or return rights. There is a seven day waiting period that applies. Employees must file a claim with the EDD to receive benefits. EDD can be reached at www.edd.ca.gov or at 877-238-4373. The employer's address to use on the form is 1850 Gateway Blvd. 7th Floor, Concord, CA 94520.

Minimum duration of CFRA leave is two weeks for the birth, adoption, or foster placement of a child. However, the Company shall grant a request for a CFRA leave of less than 2 weeks duration on any two occasions. FMLA does not require the Company to provide intermittent or reduced leave schedule for child care leave; the Company applies the CFRA-criteria to FMLA in this case. A return to your former or equivalent position and location is generally guaranteed.

Spouses (FMLA)/Parents (CFRA) who both work for the Company share their FMLA/CFRA entitlements when both taking leave for this reason.

A Leave of Absence must be initiated for job protection through the Company's Leave Administrator and appropriate documentation must be submitted for approval. Thirty days' advance notice is required when the leave is "foreseeable."

Leave to Care for a Spouse, Registered Domestic Partner (CFRA only), Parent or Child with a Serious Health Condition

If you need time off to care for a spouse, registered domestic partner, parent or child (including the child of a registered domestic partner) with a serious health condition, you may be eligible to take up to 12 weeks of paid or unpaid FMLA/CFRA leave in a rolling 12-month period. Medical certification of a "serious health condition" is required. Leave may be taken on a continual, intermittent or reduced schedule basis. A return to your former or equivalent position and work location is generally guaranteed.

A child is defined as: biological, adopted, foster child, step-child, legal ward, or child of a person standing *in loco parentis*, who is either:

- Under 18 years of age; or
- 18 years of age or older and incapable of self-care due to mental or physical disability within the meaning of Government Code section 12926, subdivisions (i) and (k) and/or the Americans with Disabilities Act (ADA).

A parent is defined as: biological, adoptive, step or foster mother or father, or other person who stood in loco parentis to the employee when the employee was a child. Grandparents and parents-in-law are not included.

Available Family Sick Leave (FSL/Sick Relative) must be used and exhausted prior to being unpaid or requesting vacation or floating holidays (paid time other than FSL pay is subject to your supervisor's approval) during an FMLA/CFRA family leave. You are not eligible to use sick pay outside of FSL during an FMLA/CFRA family leave. The use of paid time does not extend the maximum period of leave as provided for under FMLA/CFRA. You are not eligible to use paid time intermittently or on a reduced schedule when on a continual leave of absence. Unpaid continual FMLA/CFRA family leave more than 10 consecutive workdays runs concurrently with a Company Personal Leave of Absence, if you are eligible.

A Leave of Absence must be initiated for job protection through the Company's Leave Administrator and a completed Health Care Provider Certification must be submitted for approval. Thirty days' advance notice is required when the leave is "foreseeable."

FMLA Military Exigency Leave

If you need time off because of any qualifying exigency due to a spouse, or a son, daughter or parent who is on covered active duty or has been notified of an impending call or order to covered active duty in the Armed Forces (including the National Guard and Reserves), you may be eligible to take up to 12 weeks of paid or unpaid FMLA leave in a rolling 12-month period. Leave may be taken on a continual, intermittent, or reduced schedule basis. A return to your former or equivalent position and work location is generally guaranteed.

Covered active duty means:

- For members of a Regular Component of the Armed Forces, covered active duty is duty during the deployment of the member with the Armed Forces to a foreign county.
- For members of a Reserve Component of the Armed Forces (members of National Guard and Reserves, covered active duty is duty during the deployment of the member with the Armed Forces to a foreign country under a call or order to active duty in a contingency operation (further explained under a provision of law referred to in section 101(a)(13)(B) of title 10, United States Code).

Deployment to a foreign country means deployment to areas outside of the United States, the District of Columbia, or any Territory or possession of the United States. It also includes deployment to international waters.

You may elect to use any available vacation or floating holidays, subject to your supervisor's approval. The use of paid time does not extend the maximum period of leave as provided for under FMLA. You are not eligible to use paid time intermittently or on a reduced schedule when on a continual leave of absence. Unpaid continual FMLA Exigency leave more than 10 consecutive workdays runs concurrently with the Company Personal Leave, if you are eligible.

You may elect to use any available vacation or floating holidays, subject to your supervisor's approval. The use of paid time does not extend the maximum period of leave as provided for under FMLA. You are not eligible to use paid time intermittently or on a reduced schedule when on a continual leave of absence. Unpaid continual FMLA Exigency leave more than 10 consecutive workdays runs concurrently with the Company Personal Leave, if you are eligible.

You can access more information from the **Leaves of Absence** section of the PG&E@Work intranet for examples of the different reasons that may qualify as a qualifying exigency.

A Leave of Absence must be initiated for job protection through the Company's Leave Administrator and be supported by appropriate documentation. Reasonable and practicable advance notice is required when the leave is "foreseeable."

FMLA Military Caregiver Leave

If you need time off as a spouse, son, daughter, parent, or next of kin to care for a covered service member/veteran of the Armed Forces, including a member of the National Guard or Reserves, for a serious injury or illness incurred in the line of duty on active duty, you may be eligible to take up to 26 workweeks of paid or unpaid leave during a single 12-month period. Leave may be taken on a continual, intermittent or reduced schedule basis, as medically necessary. Medical Certification is required. A return to your former or equivalent position and work location is generally guaranteed.

Covered service member/veteran means:

- A member of the Armed Forces (including a member of the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness; or
- A veteran who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness and who:
  - was a member of the Armed Forces (including a member of the National Guard or Reserves)
  - was discharged or released under conditions other than dishonorable; and
  - was discharged within the five-year period preceding the date the eligible employee first takes FMLA military caregiver leave to care for the veteran (special rules apply to determine the five year period)

CFRA will run concurrently with FMLA Military Caregiver Leave when leave is taken for an eligible family member as provided for under CFRA. Unpaid continual FMLA Military Caregiver leave more than 10 consecutive workdays runs concurrently with a Company Personal Leave of Absence, if you are eligible.

Available Family Sick Leave (FSL/Sick Relative) must be used and exhausted prior to being unpaid or requesting vacation or floating holiday pay (paid time other than FSL pay is subject to your supervisor's approval) during a FMLA Military Caregiver leave. The use of paid time does not extend the maximum period of leave as provided for under FMLA. You are not eligible to use paid time intermittently or on a reduced schedule when on a continual leave of absence.

Spouses employed by the same employer are limited to a **combined** total of 26 workweeks in a "single 12-month period" if the leave is to care for a covered service member with a serious injury or illness.

You can access more information from the **Leaves of Absence** section of the PG&E@Work intranet for additional details on the FMLA Military Caregiver Leave, including the definition of serious illness or injury and who qualifies as a covered service member/veteran.

A Leave of Absence must be initiated for job protection through the Company's Leave Administrator and a completed Health Care Provider Certification must be submitted for approval. Thirty days' advance notice is required when the leave is "foreseeable."

Company Personal Leaves

Company Child Care/Bonding Leave

Under the Company's policy, if you are a regular-status employee, you may request an unpaid Company Child Care/Bonding Leave of up to six months if you need time off to bond with a newborn child, a newly-adopted child, or a newly-placed foster child (including the newborn child, a newly-adopted child or a newly-placed foster child of a registered domestic partner). An additional six months of leave may be requested; however, the maximum length of this leave, including extensions, is 12 consecutive months in combination with all other leaves, excluding a military leave. This leave must be taken and completed within three years following the birth, adoption or foster placement of your child. This leave is an unpaid absence of more than 10 consecutive workdays and cannot be taken on an intermittent or reduced schedule basis.

The Company Child Care/Bonding Leave is available once per qualifying event/child and may run concurrently with an unpaid, continual FMLA/CFRA leave.

If your leave is completed within six consecutive months, return to your former or equivalent position and work location is generally guaranteed. If you extend your Company Child Care Leave beyond six consecutive months, you may return to work provided a vacancy in your position and headquarters, or a lower position in your headquarters exists. If a vacancy of this kind does not exist, then your employment with the Company will be terminated. This leave will not be granted to cover a period of incarceration or if the purpose for which it is requested may lead to your resignation.

If you fail to return immediately on the expiration of your approved Company Leave, accept other employment while on a Company Leave (with certain exceptions), or make an application for unemployment benefits while on a Company Leave, you will no longer be considered on an approved Company Leave and your employment with the Company will end.

A Leave of Absence must be initiated through the Company's Leave Administrator. Appropriate documentation must be submitted to the Leave Administrator for approval. Thirty days' advance notice is required when the leave is "foreseeable."

Other Personal Leave

If you are a regular-status employee, you may request an unpaid leave if you have any other urgent or substantial personal reasons not already discussed in this section. A Personal Leave may be granted for a period not in excess of six consecutive months. An extension may be granted for up to an additional six consecutive months if the circumstances warrant. The maximum length of this leave, including extensions, is 12 consecutive months in combination with all other leaves, excluding a military leave. A return to your former or equivalent position and work location is generally guaranteed.

This leave is an unpaid absence of more than 10 consecutive workdays and cannot be taken on an intermittent or reduced schedule basis.

The approval of the leave is based on the merit of the request, your length of service, your performance, and the Company's business needs. This leave will not be granted to cover a period of incarceration or if the purpose for which it is requested may lead to your resignation. The Company may refuse to grant the leave if the request would cause undue hardship to the Company's operation.

If you fail to return immediately on the expiration of your approved Company Leave, accept other employment while on a Company Leave (with certain exceptions), or make an application for unemployment benefits while on a Company Leave, you will no longer be considered on an approved Company Leave and your employment with the Company will end.

A Leave of Absence must be initiated through the Company's Leave Administrator. Appropriate documentation must be submitted to your supervisor and the Leave Administrator for approval. Thirty days' advance notice is requested.

Military Leave of Absence

A Military Leave of Absence will be granted to eligible employees for up to a cumulative of five years (additional time and provisions may be available under USERRA) for service in the uniformed services, which includes duty on a voluntary or involuntary basis.

Duty means:

- active duty;
- active duty for training;
- initial active duty for training;
- inactive duty training;
- full-time National Guard duty; or
- time needed for examination to determine fitness for duty.

Uniformed services means:

- the Armed Services;
- the Army National Guard when engaged in active duty training;
- the Air National Guard when engaged in active duty training;
- full-time National Guard duty;
- the commissioned corps of the Public Health Service; or
- any other category of persons designated by the President in times of war or emergency.

Advance verbal and/or written notice to your supervisor and the Company's Leave Administrator, including a copy of the orders or other supporting documentation issued by the Military (when applicable), is required.

Supplemental Pay

Up through August 31, 2011, if you are a regular-status employee, you are eligible to receive a pay supplement for up to 17 workdays per year for reserve and active duty. If you have not attained regular status and you are participating in reserve or active duty, you may take time off without pay.

Effective September 1, 2011, from date of hire, you are eligible to receive a pay supplement for up to 17 workdays per year for reserve and active duty. To receive a pay supplement, you must provide a copy of your military orders, the military statement of earnings and certified expense statement related to the annual training or active duty to the Payroll Department within one month of your return to work. Please contact the Payroll Department for questions relating to the receipt of a pay supplemental.

Additional pay supplements may be available beyond 17 workdays if you are covered under the Emergency Active Military Leave of Absence policy (effective dates noted above apply to this policy as well). Please see *Emergency Active Military Leave of Absence* section for more information.

Contract, agency, or Hiring Hall employees who are participating in reserve training or active duty can take time-off without pay.

Health Plan Coverage

If you leave your job to perform military service, you have the right to elect to continue your existing Company health care plan coverage for up to 24 months while in the military. See "Benefit Coverage for Each Leave Type" under "You Take an Unpaid Leave of Absence" in the *What If…* section for additional information.

Re-Employment Rights

If you receive an honorable discharge from a uniformed service, you are entitled to re-employment rights and benefits provided that:

- the Company was given advance written or verbal notice of employee's service;
- cumulative length of all military service leave from the Company does not exceed five years (certain types of service in the uniformed services are exceptions to this five-year service limit); and
- applicable documentation and timing requirements are met.

You can access more information from the **Leaves of Absence** section of the PG&E@Work intranet for additional details on Military Leave, including applicable documentation and timing requirements based on length of time off due to military service.

A Leave of Absence for uniformed service of any length must be initiated through the Company's Leave Administrator. Appropriate documentation as described in the **Leaves of Absence** section of the PG&E@Work intranet must be submitted to the Leave Administrator for approval. Reasonable and practicable advance notice is required when the leave is "foreseeable."

Emergency Active Military Leave of Absence

The Emergency Active Military Leave policy was enacted to reduce the adverse financial impact on employees activated for military duty in the time of a national emergency. The policy allows employees to receive pay supplements that are equivalent to their base pay minus taxable wages received from the military, and extended medical, dental and vision coverage for themselves and their Eligible Dependents. The policy was implemented for employees required to provide military service under the terms of Executive Order 13223 of September 14, 2001, Declaration of National Emergency by Reason of Certain Terrorist Attacks (and its amendments).

In order to receive pay supplements, you are required to provide the Payroll department with a copy of your military orders, the military statement of earnings and certified expense statement in order to start receiving your supplemental pay during your Emergency Military leave; otherwise the leave will remain unpaid. You will be required to provide a copy of your military earnings each month of your leave, as feasible, in order to continue to receive supplemental pay. Contact the Payroll Department for more information on this process.

You can access more information from the **Leaves of Absence** section of the PG&E@Work intranet for additional details on Emergency Military Leave.

A Leave of Absence must be initiated through the Company's Leave Administrator. Appropriate documentation (copy of military orders or other supporting documentation issued by the Military) must be submitted to the Leave Administrator when requested and applicable (i.e., for period of service greater than 30 days). Reasonable and practicable advance notice is required when the leave is "foreseeable."

Spouses of Deployed Military Personnel (California employees only)

A leave policy for employees who are spouses of deployed military personnel was enacted by the California State Legislature in 2007 as a provision of the Military and Veterans Code. The policy allows the spouse of a deployed military member to take up to 10 days of unpaid leave while the service member is on leave from a military deployment. The military member must be deployed as a result of a military conflict.

A military member means a member of:

- the Armed Forces of the United States,
- the National Guard, or
- the Reserves.

PG&E extends this policy to employees who are registered domestic partners of deployed military members.

- To qualify for this leave, you must work at least a 20-hour per week schedule. Your leave must be taken concurrently with the leave of the service member. Some or all of this time may run concurrently with FMLA exigency leave, if you are eligible.

A return to your former or equivalent position and work location is generally guaranteed.

A Leave of Absence must be initiated through the Company's Leave Administrator. You must notify your supervisor and the Leave Administrator of your intent to take this leave within two days of receiving official notice of your military spouse/registered domestic partner's leave and must submit written documentation of their leave orders.

Union Business Leave

You may request an unpaid leave for the purpose of engaging in union business. The leave, if approved, is issued for the estimated time needed. The maximum length of the leave is not to exceed a total of:

- 72 consecutive months for members of IBEW,
- 24 consecutive months for members of ESC, or
- 12 consecutive months for members of SEIU.

Return to your previous position (or equivalent) is guaranteed only if you return to work within six months of the date on which your leave began. If you take a Union Business Leave, your medical, dental and vision coverage will terminate at the end of the month in which you go on leave.

If you return to work from a Union Business Leave that lasts longer than six month, you will not be granted another Union business Leave until you have worked for a period equivalent to the duration of the last continuous absence for union business.

Other Time Off

You may be eligible for time off for other reasons, including:

- Jury Duty
- Funerals
- Adoption
- Voting
- Family School Partnership Act (FSPA)

"Company" Defined

Throughout this section of the Handbook, reference to "Company" means Pacific Gas and Electric Company.

- Victims of Domestic Violence, Sexual Assault, or Stalking Act (VDVA)
- Victims of Crime Act (VCA)
- Victims of Crime to Testify
- Civil Air Patrol Leave
- Emergency Duty Leave and Volunteer Firefighter Training
- San Francisco Family Friendly Workplace Ordinance (SF FFWO)

Jury Duty

The Company recognizes jury duty as an important civic duty. You are eligible for time off with pay if you are a regular-status employee. If you are called for jury duty; and you are:

- a full-time employee, you will be granted the necessary time off with pay, or
- a part-time employee, you will be granted time off with pay for the number of hours you are scheduled to work during the basic workday and work week.

If you are not a regular-status employee, you may be granted time off without pay.

You must:

- advise your supervisor on the workday following receipt of notice that you are required to report for jury duty service and you may be required to provide receipt of such notice to your supervisor,
- report to work on non-court days and may be required to provide updates on the trial schedules and court appearances, and
- return to work if the dismissal from court occurs on your regular workday and the time allows you to work two hours or more before the conclusion of your regular work schedule.

Funerals

You may be granted time off with pay, up to a maximum of three days, if a member of your immediate family dies. You are eligible for time off with pay if you are a regular-status employee. An “immediate family member” is defined as:

- your spouse or registered domestic partner;
- your child (including step-children, children of your registered domestic partner, foster children, or children for whom you have been appointed legal guardianship);
- your parent (including foster parents, step-parents, parents-in-law, or parents of your registered domestic partner);
- your brother or sister (including half-, step- and foster brothers and sisters);
- your grandparent or grandparent-in-law, or those of your registered domestic partner;
- your grandchild;
- your son-in-law or daughter-in-law;
- your uncle or aunt; or
- a person who was a member of your immediate household at the time of his or her death.

You may use vacation or floating holidays, if applicable, to extend your funeral leave beyond the three days provided for, or request personal time off without pay for the time needed.

You may also request up to one full day off to attend the funeral of any other person to whom you may be reasonably deemed to owe respect.

If you are not a regular-status employee, you may be granted time off without pay.

Adoption

You may request up to a maximum of 8 hours of time off with pay, if necessary, for court appearances in connection with each child adoption proceeding if you are a regular-status employee. Time may be taken in increments of one hour or more. If you are a part-time employee, you may be granted time off with pay for the number of hours you are scheduled to work on that day.

If you are not a regular-status employee, you may be granted time off without pay.

The Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA) and the Company also provide for paid and unpaid personal leaves of absence for time off related to the adoption, including time for child bonding. The Company provides an adoption assistance benefit of up to $2,000 for each child you adopt to help pay for adoption-related expenses. See "Personal Leaves of Absence" on page 444 and "Adoption Expense Reimbursement Program" in the *Work/Life Benefits* section for more information.

Voting

If you do not have sufficient time outside of working hours to vote, you are entitled to paid time off, up to two hours if needed, to vote. You must notify your supervisor in advance of the election day if you wish to take this additional time off. Any approved time off will be taken either at the beginning or the end of your workday, whichever allows you the most time to vote.

Family School Partnership Act (FSPA)

The Family School Partnership Act (FSPA) allows eligible employees to take time off from work to participate in school activities for their children who are in grades kindergarten through twelve or attending a licensed day care facility. To be eligible, you must be a parent, guardian or grandparent who has custody of a child enrolled in a California public or private school, kindergarten through grade twelve, or licensed child day care facility.

You may take off a maximum of eight hours per month, up to a maximum of 40 hours in a calendar year. To accommodate employees who work an alternate work schedule, additional hours over the monthly maximum may be allowed. Part-time employees are allowed prorated hours based on their work schedules.

You must use paid time off (vacation or floating holidays; prescheduled, unanticipated, or unscheduled as appropriate) before using any unpaid time, and you must request the time off from your supervisor at least two workdays in advance. The Company may require verification of participation in the school activities. If both parents work for the Company at the same worksite, the FSPA covered absence would apply to the parent who gives notice first. However, the other parent may take the planned absence simultaneously for the same child and event, provided that he or she receives supervisor approval.

Victims of Domestic Violence, Sexual Assault or Stalking Act (VDVA)

If you are a victim of domestic violence, sexual assault, or stalking, you may take paid or unpaid time off under the Victims of Domestic Violence, Sexual Assault, or Stalking Act (VDVA) to seek medical attention, obtain services or psychological counseling, or participate in safety planning related to domestic violence, sexual assault, or stalking. VDVA time off may be charged in hourly increments.

You must inform your supervisor and the Company's Leave Administrator at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 866-369-7582 at least five days in advance of the need to take time off to attend to any of the qualifying events under VDVA. You may also be required to provide qualified certification to the Company's Leave Administrator prior to taking time off.

For unforeseeable qualifying events, you must notify your supervisor and the Company's Leave Administrator at the beginning of a workday, or with as much advance notice as possible, of the need to take time off to attend to any of the qualifying events under VDVA. In addition, you may also be required to provide qualified certification to the Company's Leave Administrator within five days after taking VDVA time off.

If an accommodation is needed for your safety while at work, please refer to the **Reasonable Accommodations and the Interactive Process** section of the PGE@Work intranet to obtain a request form or email the Stay-At-Work

Team at hropsinteractiveD@pge.com. You may also be required to provide qualified certification for your continued victim's status as part of the review for a reasonable accommodation.

You may elect to use paid sick leave, family sick leave (for care of an eligible family member), vacation or floating holidays for eligible VDVA absences.

Qualifying Events

The events that qualify you to take VDVA time off include:

- obtaining or attempting to obtain any relief, including, but not limited to, a temporary restraining order, restraining order, or other injunctive relief, to help ensure the health, safety, or welfare of you or your child;
- seeking medical attention for injuries caused by domestic violence, sexual assault, or stalking;
- obtaining services from a domestic violence shelter, program or rape crisis center as a result of domestic violence, sexual assault, or stalking;
- obtaining psychological counseling related to an experience of domestic violence, sexual assault or stalking; or
- participating in safety planning and taking other actions to increase safety from future domestic violence, sexual assault or stalking, including temporary or permanent relocation.

Qualified Certification

The information that satisfies any certification requirements includes:

- a police report indicating that you were a victim of domestic violence, sexual assault or stalking;
- a court order protecting or separating you from the perpetrator of an act of domestic violence, sexual assault or stalking;
- other evidence from the court or prosecuting attorney that you appeared in court; or
- documentation from a medical professional, domestic violence counselor, a sexual assault counselor, a licensed health care provider or counselor that you were undergoing treatment for physical or mental injuries or abuse resulting in victimization from an act of domestic violence, sexual assault, or stalking.

If applicable, paid or unpaid time off under VDVA may count toward your Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) entitlement (e.g., time off to seek medical attention or psychological counseling if it meets the federal FMLA and state CFRA "Serious Health Condition" criteria). However, VDVA time off does not extend the maximum period of leave that you may be entitled to under FMLA and CFRA.

Victims of Crime Act (VCA)

If you or your immediate family member is a victim of a violent or serious crime (felony) including theft or embezzlement, you are eligible for paid or unpaid time off with job protection to appear in court as a witness or to attend any judicial proceeding related to that crime under the Victims of Crime Act (VCA).

An "immediate family member" is defined as (for the purposes of this law):

- your spouse or registered domestic partner;
- your child (step-children, children of your registered domestic partner, foster children, legally adopted children or children whom you have been appointed legal guardian);
- your brother or sister (including half-and step-brothers and sisters); and
- your parent (including step-mother or step-father).

You may elect to use vacation or floating holidays, if applicable, for eligible VCA absences.

You must inform your supervisor and the Company's Leave Administrator at company extension 8-223-4357, externally at 415-973-4357, or toll-free at 866-369-7582 at least five days in advance or as soon as you become aware of the need to take time off to testify, unless the advance notice is not feasible. You may be required to provide qualified certification to the Company's Leave Administrator prior to taking time off.

For unforeseeable qualifying events, you must notify your supervisor or the Company's Leave Administrator of the need to take time off under VCA at the beginning of a workday, or with as much advance notice as possible. You may be required to provide qualified certification to the Company's Leave Administrator within five days after taking time off.

Qualified Certification

You may be required to provide the Company's Leave Administrator with written notification of each scheduled proceeding and/or evidence from the court, prosecuting attorney, or the advocating victims/witness office that you or your eligible immediate family member appeared in court.

Victims of Crime to Testify

If you are a victim of an offense, you are eligible for paid or unpaid time off from work to appear in court to be heard at any proceeding, including any delinquency proceeding, involving a postarrest release decision, plea, sentencing, postconviction release decision, or any proceeding in which a right of the victim is at issue.

Victim means any person who suffers direct or threatened physical, psychological, or financial harm as a result of the commission or attempted commission of a crime or delinquent act. Victim also includes the employee's spouse, parent, child, sibling, or guardian.

The offenses include all of the following (as defined in the Penal Code):

- Vehicular manslaughter while intoxicated;
- Felony child abuse likely to produce great bodily harm or a death;
- Assault resulting in the death of a child under eight years of age;
- Felony domestic violence;
- Felony physical abuse of an elder or dependent adult;
- Felony stalking;
- Solicitation for murder;
- A serious felony;
- Hit-and-run causing death or injury;
- Felony driving under the influence causing injury; or
- Sexual assault as set forth in certain sections of the Penal Code.

You may elect to use vacation or floating holidays, if applicable, for eligible absences.

You must inform your supervisor and the Company's Leave Administrator at company extension 8-223-4357, externally at 415-973-4357, or toll-free at 866-369-7582 at least five days in advance or as soon as you become aware of the need to take time off to testify, unless the advance notice is not feasible. You may be required to provide qualified certification to the Company's Leave Administrator prior to taking time off.

For unforeseeable qualifying events, you must notify your supervisor or the Company's Leave Administrator of the need to take time off to testify at the beginning of a workday, or with as much advance notice as possible. You may be required to provide qualified certification to the Company's Leave Administrator within five days after taking time off.

Qualified Certification

You may be required to provide the Company's Leave Administrator with one or more of the following:

- A police report indicating you were a victim of an offense specified;
- A court order protecting or separating you from the perpetrator of an offense specified or other evidence from the court or prosecuting attorney that you have appeared in court; or
- Documentation from a medical professional, domestic violence counselor, a sexual assault counselor, a licensed health care provider or counselor that you were undergoing treatment for physical or mental injuries or abuse resulting in victimization from an act of domestic violence, sexual assault, or stalking.

Civil Air Patrol Leave

If you are a volunteer member of the California Wing of the civilian auxiliary of the United States Air Force (Civil Air Patrol) and you have been directed to respond to an emergency operational mission of the California Wing of the Civil Air Patrol, you are eligible for a leave of absence if you have been employed by the Company at least 90 days immediately preceding the commencement to your leave, An eligible employee may take up to 10 days per year. Leave is limited to three days on any one occasion, but can be extended if authorized by the government entity that called for the mission and the employer agrees.

You may request to use available vacation or floating holidays (paid time subject to your supervisor's approval). You need to give as much notice as possible to your supervisor of the start and end dates to your Civil Air Patrol leave. Certification from the proper Civil Air Patrol authority to verify the eligibility for the leave requested or taken is required. You may be denied the leave to be taken as Civil Air Patrol leave if the required certification is not provided within a reasonable timeframe. A return to your former or equivalent position and work location is generally guaranteed.

Emergency Duty Leave and Volunteer Firefighter Training

If you are performing emergency duty as a volunteer firefighter, a reserve peace officer, or emergency rescue personnel, you may be eligible for time off. An eligible employee may take time off as needed in order to perform this emergency duty. This statute does not apply to any public safety agency or provider of emergency medical services when, the employee's absence would hinder the availability of public safety or emergency services.

If you are a volunteer firefighter, a reserve peace officer, or emergency rescue personnel, you may also be eligible to take a temporary leave of absence for the purposes of engaging in fire, law enforcement, or emergency rescue training. An eligible employee may take up to an aggregate of 14 days per calendar year, when taken for the purpose of engaging in fire or law enforcement training.

Volunteer firefighter means a person registered as a volunteer member of a regularly organized fire department. Emergency rescue personnel means any person who is an officer, employee, or member of a fire department or fire protection or firefighting agency of the federal government, the State of California, a city, county, city and county, district, or other public or municipal corporation or political subdivision of this state, or of a sheriff's department, police department, or a private fire department, whether that person is a volunteer or partly paid or fully paid, while he or she is actually engaged in providing emergency services.

You may request to use available vacation or floating holidays (paid time subject to your supervisor's approval). If the need for time off is foreseeable, you must inform your supervisor at least five days in advance. If the need for time off is unforeseeable, you must inform your supervisor at the beginning or your workday or with as much advance notice as possible.

San Francisco Family Friendly Workplace Ordinance (SF FFWO)

This Ordinance provides for employees who are headquartered in the City of San Francisco or the County the opportunity to request a temporary flexible or predictable work schedule

If you are a Management, Administrative & Technical, or ESC-represented employee headquartered in San Francisco, who has been employed by the company for six months, and work at least 8 hours per week, you are eligible to request a temporary flexible or predictable work schedule.

The ordinance requires employers to engage in a discussion with an employee to determine whether the company is able to accommodate the alternate work schedule request. Employers have the right to decline a request based on business needs.

Requests will be considered for up to 12 weeks in a 12-month rolling calendar period. Employees may make two requests a year as per the Ordinance — for a total of 12 weeks in a 12-month rolling calendar timeframe.

To request a temporary flexible or predictable work schedule, your first step is to have a discussion with your supervisor. Secondly, you must complete the SF FFWO Temporary Flexible or Predictable Work Schedule Request Form and submit it to the HR Ops Interactive Discussion team. Additional information can be obtained by visiting the **Workforce Health** section of the PGE@Work intranet.

Work/Life Benefits

This section covers work/life benefits that are available to eligible employees of the Company. Eligible employees are defined in the description of each program. These benefits include:

- Adoption Expense Reimbursement Program: The program provides employees up to $2,000 for reimbursement of eligible expenses related to the adoption of children under the age of 18, including stepchildren.
- Commuter Transit Program: Provides you with the opportunity to purchase transit passes and pay for certain parking expenses with pre-tax contributions.
- Employee Discount: Pacific Gas and Electric Company offers its employees a 25% discount on Pacific Gas and Electric Company-supplied gas for an employee's primary residence (domestic use only). The discount for PG&E supplied electric service is 25% discount on the full Tier 1 rate plus 25% of the charges for all usage in excess of baseline calculated using the Tier 2 rate.
- Legal/Financial Solutions (ValueOptions): Legal/Financial Solutions is available through the Company's Employee Assistance Program (EAP). If legal advice is needed, you can speak with a licensed attorney by telephone or in person. If financial advice is needed, you can speak with a certified financial advisor by telephone.
- PG&E Children's Center: The Children's Center, located at 77 Beale Street in San Francisco, provides day care for children ranging from six weeks to five years of age.
- Tuition Refund Program: The Tuition Refund Program allows you the opportunity to enroll in approved courses to support your educational goals. These approved courses are designed to assist you in performing your current duties in the most productive manner possible and to help enable you to assume new duties in the future.
- Work/Life Program (ValueOptions): The Work/Life program, administered by ValueOptions (VO), provides information and assistance in locating quality child care or elder care services locally and nationwide. Additional Work/Life resources are available.

In This Section

Adoption Expense Reimbursement Program

Pacific Gas and Electric Company, and PG&E Corporation and its covered affiliates (referred to collectively as the "Company" in this section), offers the Adoption Expense Reimbursement program. The PG&E Adoption Expense Reimbursement Program provides employees up to $2,000 for reimbursement of eligible expenses related to the adoption of children under the age of 18, including stepchildren. There is no limit on the number of adoptions eligible for reimbursement per employee. However, if both parents are Company employees, only one employee can apply for reimbursement for any single adoption. In addition, if one parent is a Company employee and his/her spouse/registered domestic partner works for a different employer who also offers an adoption expense program, the programs will be coordinated so that the combined reimbursement from both employers will not exceed 100% of the total allowable expenses incurred.

Eligibility

All employees who have completed six months of employment and who are on active payroll or are on an approved leave of absence when the adoption is made final are eligible to participate in the Adoption Expense Reimbursement Program. The Adoption Expense Reimbursement Application must be submitted within one year of the date of the final order.

You and your spouse/registered domestic partners and dependents are not eligible for the Adoption Expense Reimbursement Program if you are a contract or agency worker, a hiring hall employee, or a retired employee. Intermittent employees and other temporary employees who are not expected to become regular employees are also not eligible for coverage.

What the Program Covers

Eligible expenses include legal, court, adoption agency and placement fees, medical expenses for the adopted child which are not covered by a medical plan, and transportation expenses associated with picking up the child. Effective August 2011, eligible expenses are expanded to include surrogacy arrangements once a point has been reached in the surrogacy-related legal process when the employee's parental role and responsibility has been affirmatively recognized or ordered by the court. Eligible expenses for the income tax credit may differ (see "Income Tax Credit").

Income Tax Credit

You may be able to take advantage of both an income tax credit and the Adoption Expense Reimbursement Program for qualified adoption expenses paid or incurred by you in connection with the adoption of an eligible child. However, you may not claim both an income tax credit and a reimbursement for the same expense. Qualified adoption expenses generally include adoption fees, court costs, attorney's fees, and traveling expenses.

Check with your tax advisor for more details.

How to Apply

Before submitting your Adoption Expense Reimbursement Application, you may want to consult with your tax advisor to determine how to take maximum advantage of both the tax credit and the reimbursement program.

You can access a copy of the Adoption Expense Reimbursement Application online from the **Adoption Reimbursement** section of the PG&E@Work intranet or you can contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Completed applications should be sent via Company mail to: Adoption Expense Reimbursement Program; 1850 Gateway Blvd., 7th Floor; Concord, CA 94520.

Claim Reimbursement

Once your application has been received and approved, your application will be processed within four weeks. The amount of your reimbursement will be reflected in your regular paycheck. Current laws require that adoption benefits in the form of cash assistance are subject to the state and federal income tax regulations.

Claims and Appeals

Claims

If you have a claim regarding a reimbursement relating to expenses, fees or other claims relating to the Adoption Expense Reimbursement Program, you can file a claim for benefits to the Benefits Department by writing to:

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

No special form or format is required in submitting a written claim for benefits; you may submit written comments, documents, records and other information relating to your claim. Please note, however, that it is the obligation of the Benefits Department to administer the Plan consistently in accordance with the provisions of the Plan.

If the Benefits Department denies your claim, 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 description of any additional material or information, if any, that is necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- a description of the Plan's review procedures and the time limits applicable to such procedures.

The Benefits Department will respond to you within a reasonable period of time, but not more than 60 days after the Benefits Department's receipt of your claim unless, due to special circumstances, the Benefits Department requires additional time to respond, up to another 60 days. If an extension of time is required, the Benefits Department will notify you within the initial 60 days of the special circumstances requiring the extension and when the Benefits Department expects to render its decision.

Appeals

If you are not satisfied with the Benefits Department's decision, you may submit a written appeal to the Employee Benefit Appeals Committee (EBAC), stating the reasons for your appeal and enclosing all supporting documentation. Please note: Your appeal to EBAC must be received by EBAC within 90 days of your receipt of notice that your claim has been denied by the Plan Administrator.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
1850 Gateway Blvd, 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, reasonable access to, or copies of, all documents, records and other information relevant to your claim for benefits. The EBAC 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.

You will receive a final ruling from EBAC within a reasonable period of time, but not more than 60 days after EBAC's receipt of your appeal unless, due to special circumstances, EBAC requires additional time to respond, up to another 60 days. If an extension of time is required, EBAC will notify you within the initial 60 days of the special circumstances requiring the extension and when EBAC expects to render its decision.

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
- an explanation of any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures.

Commuter Transit Program

Pacific Gas and Electric Company, PG&E Corporation and its covered affiliates (referred to collectively as the "Company" in this section), offers its employees the opportunity to purchase transit products and passes, and pay for certain parking expenses with pre-tax contributions through the Commuter Transit Program. The program is under the management of Human Resources and is administered by a third party, ADP, Inc. For additional information about the program you can contact ADP, Inc. at 800-654-6695. Information is also available on the PG&E Intranet, under "Work/Life Benefits" at http://pgeweb/services/Pages or through the ADP website for registered users (see "Eligibility" for more information).

The Commuter Transit Program is a Company practice and is not subject to employee benefits regulations including, but not limited to, ERISA.

Eligibility

All employees of the Company except temporary employees or contract, agency, leased or retired employees are eligible to participate in the Commuter Transit Program. In order to participate, you must enroll online. To enroll online go to the ADP website, www.flexdirect.adp.com, to register. Once you register, you will be able to place and manage your future transit and/or parking orders.

Special note regarding your Social Security number (SSN) at ADP – When interacting with ADP, you will be prompted for your SSN from time to time. For your privacy, PG&E uses a formula consisting of your PG&E personnel number preceded by leading "9"s to form a nine-digit number. For example, if your personnel number is 234567, your SSN at ADP will be 999234567.

Benefits

You must elect to participate or change your participation no later than the fifth calendar day of any month in order to receive or modify commuter benefits for the following month. If you select recurring orders, the options you elect will remain the same from month to month until you change or cancel your order.

Based on IRS regulations, the maximum pre-tax contributions you may make each month toward the cost of eligible commuter expenses are:

- Mass Transit: $130
- Parking: $250

These limits may be updated periodically by the IRS.

Eligible commuter expenses include the costs for:

- BART tickets,
- Muni Fast Passes,

- Passes, vouchers, or tickets for other subways, metros, buses, trains or ferries,
- Cash value placed on a Clipper card,
- Vanpooling in a qualified commuter highway vehicle, and
- Parking at or near your company work location or where you board a transit system.

Forfeitures

Parking claims for reimbursement not submitted within 12 months of the date incurred are not eligible for reimbursement. Under IRS regulations, you may only be reimbursed for eligible expenses incurred before your retirement or termination date. If you retire or your employment with the Company terminates, voluntarily or involuntarily, you have 90 days after the date employment ends to submit your claim for eligible expenses incurred while you were an active employee. Any funds left in your account after the claims filing deadline will be forfeited. In addition, unused balances of specific commuter products are considered forfeit once you retire or your employment with the Company terminates. Completed transit orders are considered non-refundable.

Employee Discount

Pacific Gas and Electric Company offers its employees a 25% discount on Pacific Gas and Electric Company-supplied gas for an employee's single family primary residence (domestic use only). The discount for PG&E supplied electric service is 25% discount on the full Tier 1 rate, plus 25% of the charges for all usage in excess of baseline calculated using the Tier 2 rate. There is no employee discount for non-tiered electric rates.

You Must Call

It is your responsibility to contact the Contact Center at 800-743-5000 to request the rate. The employee rate is not automatic.

The Employee Discount is a Pacific Gas and Electric Company practice and is not subject to employee benefits regulations including, but not limited to, ERISA.

Eligibility

You are eligible for this discount if you are an employee of Pacific Gas and Electric Company and you have completed six months of continuous service and attained regular status. (This includes employees on Military Leave.)

In order to receive this benefit you must:

- live within the Pacific Gas and Electric Company's service territory, and
- have the service in your name at your primary residence.

An employee is eligible to receive employee rates only at the employee's principal residence. However, a General Construction employee or other employee similarly required to be away from his/her principal residence on PG&E work assignment is eligible for the discount while occupying a second residence.

Employees who are eligible for the discount under residential single family rate, and who have two separate meters providing residential service to their principal residence, may receive the employee rate discount on both services. For example, one meter serves the home and the second meter serves a domestic well pump. Where the meter serves more than one residence, such as a duplex, employee rates are not applicable.

Where two or more PG&E Company employees share the same, single-metered, primary residence, only one employee rate discount may be claimed for that residence. Employees residing in such a shared residence who are not the customer of record for that residence may not apply for an employee discount at an alternate residence, which is not their primary residence.

You are also eligible for this discount if you are a qualified pensioner of Pacific Gas and Electric Company. A qualified pensioner is any employee who worked for the Company and retired at the age of 55 or greater. Employees who retire from PG&E Corporation are not entitled to the employee discount.

You are not eligible for benefits if you are a summer hire, summer technical intern, contract employee, agency employee, or leased employee. Intermittent employees and other temporary employees who are not expected to become regular employees are also not eligible for coverage. In addition, you are not eligible if you are an employee of:

- any subsidiary of Pacific Gas and Electric Company;
- any affiliated company; or
- PG&E Corporation or any affiliated company of PG&E Corporation.

When an employee's employment with the Company is terminated for a reason other than retirement, the Human Resource department shall immediately notify Customer Billing, which shall remove the employee's residence from residential employee rates effective on the date employment is terminated. This includes termination of employment with the Company prior to rehire as an employee of the PG&E Corporation or one of its non-utility subsidiaries.

Requesting the Discount and Change of Residence

You must call the Contact Center at 800-743-5000 to:

- Request the discount for the first time, or
- Transfer the discount to a new location.

Legal/Financial Solutions (ValueOptions)

Pacific Gas and Electric Company, and PG&E Corporation and its covered affiliates (referred to collectively as the "Company" in this section) offer Legal/Financial Solutions through the Company's Employee Assistance Program (EAP), administered by ValueOptions (VO).

If legal advice is needed, you can speak with a licensed attorney by telephone or in person. If financial advice is needed, you can speak with a certified financial advisor by telephone.

Common legal topics include:

- Alimony/Child Support
- Adoption
- Living Wills
- Powers of Attorney
- Foreclosures

Common financial topics include:

- Savings Strategies
- Debt Management
- Retirement Planning
- Credit Scores

Eligibility

Legal/Financial Solutions is available to all Company employees, their spouses/registered domestic partners and Eligible Dependents.

You and your spouse/registered domestic partner and dependents are not eligible for this benefit if you are a contract or agency worker, a hiring hall employee, or a retired employee. Intermittent employees and other temporary employees who are not expected to become regular employees are also not eligible for coverage.

Cost

Legal Solutions

After your initial call to VO, if further legal services are needed, you can be referred to an attorney in private practice in your area who handles your kind of legal problem. The attorney will provide a 30-minute telephonic or face-to-face consultation at no cost to you. If legal representation is needed beyond the 30 minutes, and you decide to hire the attorney for further services, you will receive a 25% discount from the usual hourly rate.

Financial Solutions

After your initial call to VO, you will be referred to a certified financial advisor for assistance. The advisor will provide a telephonic consultation at no cost to you.

How to Use Legal/Financial Solutions

To request legal or financial services, simply call the toll-free EAP Hotline at 888-445-4436. A counselor will assess your needs and connect you with an attorney or financial advisor as appropriate. Exclusions

Exclusions

The VO-referred attorneys cannot provide legal services for these four matters:

- Employment Issues — Potential legal disputes between employees and employers.
- Corporate Law — Advice on any business or commercial enterprise belonging to you, your spouse or registered domestic partner.
- Second Opinions — Advice on how another attorney is handling a legal matter for you.
- Third-Party Advice — Advice on a question involving someone other than you, your spouse/registered domestic partner, or dependents.

PG&E Children's Center

Pacific Gas and Electric Company, and PG&E Corporation and its covered affiliates, (referred to collectively as the "Company" in this section), offers the PG&E Children's Center. The Children's Center, located at 77 Beale Street in San Francisco, provides day care for children ranging from six weeks to five years of age. The Children's Center is managed by an external vendor, Bright Horizons Family Solutions.

Eligibility and Enrollment

The Children's Center is open for use by children of all union-represented employees who have a regularly scheduled work week of at least 40 hours and who work in the San Francisco General Office complex and surrounding offices.

You are not eligible for the Children's Center benefit if you are a contract or agency worker, a hiring hall employee, or a retired employee. Intermittent employees and other temporary employees who are not expected to become regular employees are also not eligible for coverage.

Enrollment

If you are eligible to use the Children's Center, call the Center at 415-972-5535, for an application. Send your completed application via Company mail to the Center's Director, 77 Beale Street, 2nd Floor, San Francisco. Once your application is received, it will be included in the enrollment lottery list, which is used to award vacant spaces in the Center.

The Lottery System

A lottery is held as soon as possible after a space for a particular age level becomes available at the Center. Spaces become available when pre-school age children leave the Center to attend kindergarten or when a family decides to withdraw their child(ren) for other reasons. Additional openings are also created throughout the year as children progress and are transitioned into a different age group.

How Space Is Allocated

The allocation of spaces is based on the percentage of employees in each employee category (Management, Administrative & Technical, IBEW Union-Represented and ESC Union-Represented) who work in downtown San Francisco. Spaces are non-transferable and cannot be shared. To ensure parity, the lottery draws are pulled in the following order:

- The out-of-parity employee categories;
- The sibling list; then
- The general application list.

Claims and Appeals

Claims and Appeals Relating to Disenrollment

Claims

If you have a claim involving disenrollment of a child in the Children's Center, your first step as a parent or guardian is to submit a written claim in a letter within ten days of receipt of the Center Director's notice to withdraw the child from the Center. Please send your claim letter to:

Bright Horizons Family Solutions
200 Talcott Avenue South
Watertown, Massachusetts 02472

No special form or format is required in submitting a written claim. Within thirty (30) days of receipt of your claim, Bright Horizons will send you a written decision.

If Bright Horizons denies your claim, you will be provided with:

- 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 description of any additional material or information necessary for you 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 your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

Appeals

If Bright Horizons denies your claim, you may submit a written appeal to the Plan Administrator, stating the reasons for your appeal and enclosing all supporting documentation. Your appeal to the Plan Administrator must be received within 60 days of your receipt of notice that your claim has been denied by Bright Horizons.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
Plan Administrator Appeals
1850 Gateway Blvd., 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, reasonable access to, or copies of, all documents, records and other information relevant to your claim for benefits. The Benefits Department's 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 in the initial benefit determination. Please note, however, that it is the obligation of the Benefits Department to administer the Plan consistently in accordance with the provisions of the Plan.

If your appeal is denied, 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;
- 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 a civil action under section 502(a) of ERISA.

You will receive a final ruling from the Benefits Department within a reasonable period of time, but not more than 60 days after the Benefits Department's receipt of your appeal unless, due to special circumstances, the Benefits Department requires additional time to respond, up to another 60 days. If an extension of time is required, the Benefits Department will notify you within the initial 60 days of the special circumstances requiring the extension and when the Benefits Department expects to render its decision.

Claims and Appeals Relating to Enrollment, Fees or Other Claims

Claims

If you have a claim relating to enrollment, fees or other claims relating to the Children's Center, you can file a claim for benefits to the Plan Administrator by writing to:

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

No special form or format is required in submitting a written claim for benefits; you may submit written comments, documents, records and other information relating to your claim. Please note, however, that it is the obligation of the Benefits Department to administer the Plan consistently in accordance with the provisions of the Plan.

If the Benefits Department denies your claim, 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 description of any additional material or information necessary for you 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 your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

The Benefits Department will respond to you within a reasonable period of time, but not more than 90 days after the Benefits Department's receipt of your claim unless, due to special circumstances, the Benefits Department requires additional time to respond, up to another 90 days. If an extension of time is required, the Benefits Department will notify you within the initial 90 days of the special circumstances requiring the extension and when the Benefits Department expects to render its decision.

Appeals

If you are not satisfied with the Benefits Department's decision, you may submit a written appeal to the Employee Benefit Appeals Committee (EBAC), stating the reasons for your appeal and enclosing all supporting documentation. Please note: Your appeal to EBAC must be received by EBAC within 60 days of your receipt of notice that your claim has been denied by the Plan Administrator.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
1850 Gateway Blvd., 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, reasonable access to, or copies of, all documents, records and other information relevant to your claim for benefits. The EBAC 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.

You will receive a final ruling from EBAC within a reasonable period of time, but not more than 60 days after EBAC's receipt of your appeal unless, due to special circumstances, EBAC requires additional time to respond, up to another 60 days. If an extension of time is required, EBAC will notify you within the initial 60 days of the special circumstances requiring the extension and when EBAC expects to render its decision.

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.

Tuition Refund Program

The Pacific Gas and Electric Company, and PG&E Corporation and its covered affiliates (referred to collectively as the "Company" in this section), offers the Tuition Refund Program. The Tuition Refund Program allows you the opportunity to enroll in approved courses. These approved courses are designed to assist you in performing your current duties in the most productive manner possible and to help enable you to assume new duties in the future.

The Tuition Refund Program is a Company practice and is not subject to employee benefits regulations including, but not limited to, ERISA.

Note: The information included in this section does not reflect all program guidelines. To view the entire Tuition Refund Program guidelines online, go to **Tuition Refund Program** on the PG&E@Work intranet.

Contact Information

If you have questions about your eligibility to participate in the Tuition Refund Program (TRP) or about your application, payment in advance, textbook reimbursement, or employee records, you should read the program guidelines in depth or contact EdLink, PG&E's Tuition Refund Program Administrator. The contact information is:

- Tuition Refund Helpline: 888-718-2235
- Email: PGETuition@edlinktuition.com

Eligibility

(See Section 1.1 of TRP Guidelines)

Union-Represented Employees:

- All full-time, active payroll employees are eligible for the full tuition allowance after completing six months of continuous service and attaining regular status.
- Part-time employees and employees with less than six months of continuous service and employees who have not attained regular status are not eligible for the Program.
- Program participants must not be under any active discipline or performance action plan.

For all other employee situations, see section 1 of the TRP Guidelines.

Tuition Refund Application

Applications must be completed online through EdLink, which can be found on the **Tuition Refund Program** section of the PG&E@Work intranet.

When you use the on-line application process, your application automatically routes to EdLink for a preliminary review and then to your respective supervisor for approval.

All applications must be submitted at least 10 days prior to the start date of each course.

Course Approval Criteria

Courses must be either job-related or career-related and meet the following criteria:

- Job-related: Related to knowledge and skills useful for the employee's present job or helps improve the employee's present job performance
- Career-related: Related to future career objectives with PG&E or qualifies the employee for a new job with PG&E

Only courses offered by accredited institutions (or "schools") are reimbursable by the Program. Educational institutions must be accredited by one of the following:

- Western Association of Schools and Colleges or one of its regional counterparts;
- California Department of Education;
- California Private Post-Secondary Education Institution; or
- Distance Education Training Council.
- To determine if the school you are interested in attending meets the above standards, use the Office of Post Secondary Education College Search Tool to identify the school's level of accreditation. This link can also be found on EdLink's website (see Section 2.2 of the Tuition Refund Program Guidelines).

Courses require advance approval by both EdLink and direct-line management, which includes:

- The employee's supervisor (or next-level manager, as appropriate) who is responsible for reviewing and approving the course application
- Human Resources who reviews and has final approval authority for all applications

Excluded Programs and Courses of Study

- The Program does not provide reimbursements for educational courses that PG&E determines in its sole discretion are personal to the employee.
- No reimbursement is available for education that involves sports, games, or hobbies unless the education has a reasonable relationship to the business of PG&E (determined by the employee's Director or above and Human Resources), or is required as part of an approved degree program.

Specific Exclusions:

- Certain concentrations of study not relevant to PG&E business or available positions are specifically excluded. This list is illustrative, but not exhaustive: Architecture, Art/Commercial Art, Aviation, Criminal Justice or Law Enforcement, Theology, Law or Legal Assisting, Occupational Therapy, Photography, or Real Estate, Executive MBA programs and Ph.D. degrees. (Refer to Corporation Standard HR-1101S, Section 3.2, for a more comprehensive list.)
- Exceptions are allowed only if the concentration is directly related to the employee's job, as determined by the employee's Director or above and the Human Resources department.
- Individual courses in excluded concentrations may be taken as electives as part of an approved degree program.
- Ph.D. and other advanced degree programs are not covered by the Program unless agreed upon by the employee's Vice President and the Senior Vice President-Human Resources. Approval will be granted only in circumstances where the advanced degree program is job-related and determined to be a business or regulatory necessity.

Certificate Programs:

- All certificate programs are reviewed on a case-by-case basis by the Human Resources department.
- Certificate programs are eligible only if they are job-related, offered by an accredited institution, approved by Human Resources, and fulfill all other Program requirements.

If the course is a certificate course where evidence of successful completion is only awarded by passing an exam, then the employee must pass the exam and receive a certificate of completion from the school in order to receive reimbursement.

Tuition Costs Covered

You are eligible for a refund of covered costs which include the following:

- Tuition
- Course registration/enrollment fees
- Laboratory and technology fees related to online courses
- Program fees, department based college academic fees, and academic fees
- Textbooks (including taxes, if applicable)

To receive a refund, eligibility must be maintained throughout the duration of the course(s).

Tuition Costs Not Covered

Costs that are not covered include:

- Materials, supplies and equipment
- Shipping and handling charges
- Food
- Lodging

- Transportation
- Examination fees (e.g., GMAT, SAT, PE)
- Parking
- Health fees

Refer to Corporation Standard HR-1101S, Section 5.3, for a more comprehensive list of ineligible costs.

Ineligible costs need to be incurred directly by the employee or in some other way (grants, loans, personal finances, etc.). Employees are encouraged to contact the school in advance to determine anticipated costs for their schooling.

Employees are responsible for ensuring that the school provides adequate and accurate itemized billing for educational costs to EdLink. Itemized bills can only be submitted to EdLink directly from the school and not by the employee.

What the Program Will Pay

IBEW- and SEIU-Represented Employees

The Plan will pay 100% of covered costs. Payment is limited to $5,250 per calendar year.

ESC-Represented Employees

After successful completion of an approved course of study, a refund of 100 % of the direct costs will be made. Direct costs apply only to registration fees, tuition, required textbooks, laboratory fees, and other charges made by the-institution such as program fees, department based college academic fees, academic fees, and technology fees required for on-line education. Costs of materials and equipment purchased separately by the employee are not covered.

The maximum annual spending cap per employee (for eligible program expenses) is $6,000 per calendar year.

In no case can payments for a calendar year exceed the respective limits outlined above. For all applications, payments are applied to a given calendar year limit based on the end date of the course.

Income Tax Implications:

Employees may incur some personal tax liability when payments on their behalf exceed $5,250 per year as these payments may be considered gross income, subject to federal, state, FICA and wage benefit taxes.

Payment Procedure

Payments can be made by the program directly to the school in advance of a course or the employee can pay for the course with their own money and be reimbursed. See section 6 of the TRP guidelines for more information.

Company credit cards should never be used to pay for course tuitions and other approved program costs. See Accounts Payable guidelines for appropriate use of “P” and “C” card expenditures.

Upon Completion of a Course

- Evidence of successful course completion is required for all courses.
  - A grade of “C” or better for letter graded courses; “C-” grades are not considered a passing grade
  - A grade of “Pass” for Pass/Fail courses
  - A letter from the school or a certificate indicating passing performance for non-graded courses
- Evidence of successful completion must be provided to EdLink for every course within 45 days of the end of the course, if such evidence has been issued by the school by that time.

- If evidence of course completion has not been issued by the school within 45 days of the end of the course, you must notify EdLink by the original deadline. Failure to meet the 45 -day deadline with evidence of successful completion or notice that such evidence is unavailable will be treated as an unsuccessful completion.
- If the school has not issued evidence of successful completion within 45 days of the end of the course and you notify EdLink of this before the deadline, you may request a grade extension (90 days from the course end date for management employees, and 120 days for union represented employees). Failure to meet the 90-day deadline with evidence of successful completion will be treated as an unsuccessful completion.
- Applications for textbook reimbursements must be submitted within 45 days after a course ends. Textbook reimbursement applications submitted after this deadline **will not** be approved.

Employee Repayments

- Participants must repay the Program for all pre-paid costs when the requirements for successful completion are not met.
  - If you receive a letter grade lower than a "C" for a letter-graded course, a grade of "Fail" for Pass/Fail courses, or cannot submit a letter from the school or a certificate indicating passing performance for non-graded courses, any pre-paid tuition will be deducted directly from your paycheck or must be paid upon request. You will also be barred from further participation in the program until full repayment for delinquent courses is complete.
  - In the event of failure to provide evidence of a successful completion by the required deadline, even if the course is otherwise successfully completed, any pre-paid tuition will be deducted from your paycheck or must be paid upon request.
  - If you terminate employment for any reason before the course is completed, you must repay any pre-paid tuition to the Program out of pocket upon request.
- No reimbursement is made for any course or textbook when the requirements for successful completion are not met, or if you terminate employment for any reason before the course is completed.
- Incomplete courses are reimbursed only under unusual circumstances such as:
  - You become disabled
  - Your working hours are changed, preventing completion.
  - You are called for extended jury duty.
  - You are promoted or transferred and move to a geographical area that is beyond a reasonable commute distance.

Note

The participant is responsible for notifying EdLink if any of these circumstances apply, and for providing appropriate documentation for the exception.

In all other situations, an incomplete course is considered unsuccessful completion.

The above is not a complete publication of PG&E's Tuition Refund Program Guidelines. Before participating in the TRP, employees should read all program guidelines in full.

Work/Life Program (ValueOptions)

The Company offers the Work/Life Program. The Company-sponsored Work/Life program, administered by ValueOptions (VO), provides information and assistance in locating quality child care or elder care services locally and nationwide. In addition, other Work/Life resources are available.

Contact

Call the following number to access Work Life services: 888-445-4436

Eligibility

The Work/Life program is available to all Company employees and their dependents.

You are not eligible for this program if you are a contract or agency worker, a hiring hall employee or a retired employee.

What the Program Provides

Some of the Work/Life services provided include:

- Telephone counseling to help identify the type of dependent care assistance you need;
- Printed educational materials to guide you in making appropriate dependent care decisions;
- Referrals that have confirmed availability and openings to state-licensed family home day care centers, child care centers, nursery schools, private and public schools, and college and vocational schools; and
- Referrals to nationwide resources on housing, health care, insurance, aging, and financial information for elderly parents.

How to Use the Work/Life Program

To request Work/Life referral services, simply call the toll-free EAP Hotline at 888-445-4436. A counselor will confirm your eligibility and connect you with a Work/Life Specialist. This service is available 24 hours a day, 7 days a week.

Rules, Regulations & Administrative Information

This section describes a number of regulations that apply to the benefits described in this Handbook, and provides some administrative details about the plans.

Not all of the plans or benefits in the Handbook are subject to all of the same laws. For example, some plans are subject to the Employee Retirement Income Security Act of 1974 (ERISA) while others are not. For information on which laws cover the plans, see "Administrative Information" beginning on page 482 for each plan.

In This Section

Plan Amendment and Termination

The Company, acting through its authorized representatives, reserves the right to amend or terminate any or all of the plans described in this Handbook at any time and for any reason, or to suspend contributions to the plans, in whole or in part, at any time, subject to any applicable collective bargaining agreements.

Any change to the plans or the termination of any plans 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 a plan for any reason without replacing it, you will be given notice.

The plans may also 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 plans.

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation. The plans and benefits described in this section are also applicable to employees of designated subsidiaries and affiliates, but only to the extent that such entities are participating employers with respect to the described plans or programs and such employees meet the eligibility requirements of the plans or programs.

Plan Administration

The PG&E Corporation Employee Benefit Committee is the Plan Administrator and is responsible for the overall administration of the plans. This committee has the sole power and discretionary authority to establish, and from time to time revise, such rules and regulations as may be necessary to administer the plan in a nondiscriminatory manner for the exclusive benefit of participants and all other persons entitled to benefits under the plans. This committee delegates to the Senior Vice President – Human Resources of PG&E Corporation and assigned staff the authority to interpret, implement, and revise rules and regulations as necessary to administer the plans in a proper and nondiscriminatory manner. Staff is also responsible for overseeing participant recordkeeping, accounting, reporting, and receipt and disbursement of plan assets, if any.

The Plan Administrator has the discretionary authority to interpret and construe the terms of the plans, to resolve any conflicts or discrepancies between documents and to establish rules that are necessary or desirable for the administration of the plans.

Your Rights Under ERISA

Participants in the plans in this Handbook that are subject to the Employee Retirement Income Security Act of 1974 (ERISA) are entitled to certain rights and protections 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 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 descriptions. The administrator may charge a reasonable fee 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 coverage (including health care flexible spending account coverage) for yourself, spouse/registered domestic partner and/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 or the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
- 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 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 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, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any 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.

Health Information Privacy and Data Security

Please Read This Carefully

This section describes how medical information about you may be used and disclosed and how you can obtain access to this information.

The Pacific Gas and Electric Company and its health plan partners are committed to protecting the privacy and confidentiality of the health information for eligible participants (including eligible employees, retirees and surviving spouses, and their Eligible Dependents) that is created or received in the administration of The Pacific Gas and Electric Company Health Care Plan for Active Employees, The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, and The Pacific Gas and Electric Company Health Care Flexible Spending Account Plan (collectively, "Health Plans").

Federal legislation known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the underlying privacy and security regulations issued by the U.S. Department of Health and Human Services provide additional protection for individually identifiable health information (referred to as "Protected Health Information"). The privacy regulations were effective April 14, 2004, and the security regulations were effective April 20, 2005. Protected Health Information includes health information in any form or medium including paper, oral communications and electronic media. For this purpose, electronic media will include health information stored on computer hard drives, any removable/transportable digital memory medium, such as a magnetic tape or disk, optical disk, or digital memory card, as well as the various methods in which health information is transmitted electronically.

The Health Plans will not use or disclose an eligible participant's Protected Health Information, except as necessary for purposes of treatment, payment or health care operations, or as otherwise permitted by applicable law. The Health Plans may also disclose an eligible participant's Protected Health Information to authorized Pacific Gas and Electric Company personnel (including personnel at affiliated companies whose employees participate in the Health Plans) for these and other administrative purposes. Neither the Pacific Gas and Electric Company nor its authorized personnel will, without the eligible participant's written authorization, use or disclose his or her Protected Health Information for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by the Pacific Gas and Electric Company.

Under HIPAA, eligible participants have certain important rights with respect to Protected Health Information, including the rights to inspect and copy information, receive an accounting of certain disclosures of health information, and under certain circumstances, amend the information that is incorrect or incomplete. Eligible participants may also request a restriction on the Protected Health Information that the Health Plans use or disclosure about their treatments, payments or health care operations, or that the Health Plans communicate with them about health matters using alternative means or at alternative locations. Eligible participants also have the right to file a complaint with the Health Plans or with the U.S. Department of Health and Human Services if they believe that their health information rights under HIPAA have been violated.

The Health Plans maintain a "HIPAA Notice of Health Information Privacy Practices" ("HIPAA Notice") that provides a description of how Pacific Gas and Electric Company and the Health Plans may use or disclose Protected Health Information, as well as eligible participants' health information rights under HIPAA. The Health Plans have implemented administrative, physical and technical safeguards designed to protect the confidentiality, integrity and availability of any Protected Health Information that it transmits, receives or maintains in any form of electronic media. See "HIPAA Notice of Health Information Privacy Practices" on page 476 and "Health Information Privacy and Data Security" on page 476 of this section.

To receive more information about the Health Plans' health information privacy practices or HIPAA rights, or if you have any questions about the HIPAA Notice, you may contact the Pacific Gas and Electric Company Plan Administrator, PG&E HR Service Center, 1850 Gateway Blvd, 7th Floor, Concord, CA 94520.

HIPAA Notice of Health Information Privacy Practices

This Notice is required by the Health Insurance Portability and Accountability Act (HIPAA) and is intended to describe to the extent applicable to you how the Pacific Gas and Electric Company Health Care Plan for Active Employees, the Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, and the Pacific Gas and Electric Company Health Care Flexible Spending Account Plan (collectively, "Health Plans"), and the various health plan vendors that administer these Health Plans (for example, Anthem Blue Cross) will protect your health information.

"Health information" for this purpose means information that identifies you and either relates to your physical or mental health condition, or relates to the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed by the Health Plans without a written authorization from you, except as described in this Notice or as otherwise permitted by federal or state health information privacy laws. Please note that your personal physician or other health care facilities (for example, hospitals or health clinics) where you may receive health care or treatment may have different policies, procedures or notices regarding the physician's or health care facility's use or disclosure of PHI that they may have created. These health care providers will separately notify you regarding their health information policies or procedures.

Health Plan Privacy Obligations

The Health Plans are required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this Notice of their legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that are in effect.

How the Health Plans May Use and Disclose Health Information About You

The Health Plans may use health information or disclose it to others for a number of different reasons. The following are the different ways that the Health Plans may use and disclose your PHI without your authorization:

- For Treatment. The Health Plans may disclose your PHI to a health care provider who provides, coordinates or manages health care treatment on your behalf. For example, if you are unable to provide your medical history as a result of an accident, the Health Plans may advise an emergency room physician about the different medications that you may have been prescribed.
- For Payment. The Health Plans may use and disclose your PHI so claims for health care treatment, services, and supplies that you receive from health care providers may be paid according to the Health Plans' terms. The Health Plans may also use your PHI for billing, reviews of health care services received, and subrogation. For example, the Health Plans may tell a doctor or hospital whether you are eligible for coverage or what percentage of the bill will be paid by the Health Plans.
- For Health Care Operations. The Health Plans may use and disclose your PHI to enable them to operate more efficiently or to make certain that all of their participants receive the appropriate health benefits. For example, the Health Plans may use your PHI for case management, to refer individuals to disease management programs, for underwriting, premium rating, activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, to arrange for medical reviews, or to perform population-based studies designed to reduce health care costs. In addition, the Health Plans may use or disclose your PHI to conduct compliance reviews, audits, legal reviews, actuarial studies, and/or for fraud and abuse detection. The Health Plans may not use or disclose genetic information for underwriting purposes.
- To The Plan Sponsor. The Health Plans are sponsored by the Company. The Health Plans may disclose your PHI to designated personnel at the Company so that they can carry out related administrative functions, including the uses and disclosures described in this Notice. Such disclosures will be made only to the individuals authorized to receive such information under the Health Plans. These individuals will protect the privacy of your health information and ensure that it is used only as described in this Notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Health Plans to any other employee or department of the Company, and (2) will not be used by the Company for any employment-related actions or decisions, or in connection with any other employee benefit plans sponsored by the Company.
- To a Business Associate. Certain services are provided to the Health Plans by third-party administrators known as "business associates." For example, the Health Plans may place information about your health care treatment into an electronic claims processing system maintained by a business associate so that your claim may be paid. In so doing, the Health Plans will disclose your PHI to their business associates so that the business associates can perform their claims payment functions. However, the Health Plans will require their business associates, through written agreements, to appropriately safeguard your health information.

- For Treatment Alternatives. The Health Plans may use and disclose your PHI to tell you about possible treatment options or health care alternatives that may be of interest to you.
- For Health-Related Benefits and Services. The Health Plans may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.
- To Communicate With Family and Others When You Are Not Present. There may be times when a family member or other person involved in your or your child's care contacts the Health Plans on your behalf because there is an emergency, you are not present, or you lack the decision making capacity to agree or object. In those instances, we will use our best judgment to determine if the disclosure of your or your child's PHI is warranted. If so, we will limit the disclosure to the PHI that is directly relevant to the person's involvement with your or your child's health care. For example, if you are hospitalized, we may provide your spouse with information about payment of your medical claims. The Health Plans may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death, unless other laws would prohibit such disclosures.
- As Required by Law. The Health Plans will disclose your PHI when required to do so by federal, state, or local law, including those laws that require the reporting of certain types of wounds, illnesses or physical injuries.

Special Use and Disclosure Situations

The Health Plans may also use or disclose your PHI without your authorization under the following circumstances:

- Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the Health Plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other forms of lawful due process.
- Law Enforcement. The Health Plans may release your PHI if asked to do so by a law enforcement official, for example, to report child abuse, to identify or locate a suspect, material witness or missing person, or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.
- Workers' Compensation. The Health Plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws and other similar programs.
- Military and Veterans. If you are or become a member of the U.S. Armed Forces, the Health Plans may release medical information about you as deemed necessary by military command authorities.
- To Avert Serious Threat to Health or Safety. The Health Plans may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.
- Public Health Risks. The Health Plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or problems with medical products; or to notify people of recalls of products they have been using.
- Health Oversight Activities. The Health Plans may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.
- Research. Under certain limited circumstances, the Health Plans may use and disclose your PHI for medical research purposes.
- National Security, Intelligence Activities, and Protective Services. The Health Plans may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law; and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.
- Organ and Tissue Donation. If you are an organ donor, the Health Plans may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- Coroners, Medical Examiners, and Funeral Directors. The Health Plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Health Plans may also release your PHI to a funeral director, as necessary, to carry out his/her responsibilities.

Your Rights Regarding Your Health Information

You have the following rights regarding the health information that the Health Plans maintain about you:

- Right to Inspect and Copy Your Personal Health Information. You have the right to inspect and copy your PHI that is maintained in a "designated record set" for so long as the Health Plans maintain your PHI. A "designated record set" includes medical information about eligibility, enrollment, claim and appeal records, medical and billing records maintained by the Health Plans, and records used in whole or in part to make decisions about your Health Plan benefits, but does not include psychotherapy notes, information intended for use in a civil, criminal or administrative proceeding, or any information to which access is otherwise prohibited by law.

  To inspect and copy health information maintained by the Health Plans, submit your request in writing to:

  Pacific Gas and Electric Company
  Plan Administrator — HIPAA
  PG&E Benefits Department
  1850 Gateway Blvd., 7th Floor
  Concord, CA 94520

  The Health Plans may charge a fee for the cost of copying and/or mailing your request. The Health Plans must act upon your request for access no later than 30 days after receipt. A single, 30-day extension is allowed if the Health Plans are unable to comply by the initial deadline. In limited circumstances, the Health Plans may deny your request to inspect and copy your PHI. Generally, if you are denied access to your health information, you will be informed as to the reasons for the denial, and of your right to request a review of the denial.

- Right to Amend Your Personal Health Information. If you feel that the health information that the Health Plans have about you is incorrect or incomplete, you may ask the Health Plans to amend it. You have the right to request an amendment for so long as the Health Plans maintain your PHI in a designated record set.

  To request an amendment, send a detailed request in writing to:

  Pacific Gas and Electric Company
  Plan Administrator — HIPAA
  PG&E Benefits Department
  1850 Gateway Blvd., 7th Floor
  Concord, CA 94520

  You must provide the reason(s) to support your request. The Health Plans may deny your request if you ask the Health Plans to amend health information that was: (1) accurate and complete; (2) not created by the Health Plans; (3) not part of the health information kept by or for the Health Plans; or (4) not information that you would be permitted to inspect and copy. The Health Plans have 60 days after the request is received to act on the request. A single, 30-day extension is allowed if the Health Plans cannot comply by the initial deadline. If the request is denied, in whole or in part, the Health Plans will provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and, if permitted under HIPAA, have that statement included with any future disclosures of your PHI.

- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your PHI. This is a list of disclosures of your PHI that the Health Plans have made to others for the six (6) year period prior to the request, except for those disclosures necessary to carry out treatment, payment, or health care operations, disclosures previously made to you, disclosures that occurred prior to April 14, 2003 (the HIPAA compliance date), or in certain other situations described under HIPAA.

  To request an accounting of disclosures, submit your request in writing to:

  Pacific Gas and Electric Company
  Plan Administrator — HIPAA
  PG&E Benefits Department
  1850 Gateway Blvd., 7th Floor
  Concord, CA 94520

Your request must state a time period, which may not be longer than six (6) years prior to the date the accounting was requested. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the Health Plans provide you with a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request an accounting more than once within a 12-month period, the Health Plans will charge a reasonable, cost-based fee for each subsequent accounting.

- Right to Request Restrictions. You have the right to request a restriction on the health information that the Health Plans use or disclose about you for treatment, payment, or health care operations. You also have the right to request that the Health Plans limit the individuals (for example, family members) to whom the Health Plans disclose health information about you. For example, you could ask that the Health Plans not use or disclose information about a surgical procedure that you had. While the Health Plans will consider your request, they are not required to agree to it. If the Health Plans agree to the restriction, they will comply with your request until such time as the Health Plans provide written notice to you of their intent to no longer agree to such restriction, or unless such disclosure is required by law.

  To request a restriction or limitation, make your request in writing to:

  Pacific Gas and Electric Company
  Plan Administrator — HIPAA
  PG&E Benefits Department
  1850 Gateway Blvd., 7th Floor
  Concord, CA 94520

  In your request, you must state: (1) what information you want to limit; (2) whether you want to limit the Health Plans' use, disclosure, or both; and (3) to whom you want the limit(s) to apply. Note: The Health Plans are not required to agree to your request.

- Right to Request Confidential Communications. You have the right to request that the Health Plans communicate with you about health matters using alternative means or at alternative locations. For example, you can ask that the Health Plans send your explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to:

  Pacific Gas and Electric Company
  Plan Administrator — HIPAA
  PG&E Benefits Department
  1850 Gateway Blvd., 7th Floor
  Concord, CA 94520

  The Health Plans will make every attempt to accommodate all reasonable requests. Your request must specify how or where you want to be contacted.

- State Privacy Rights. You may have additional privacy rights under state laws, including rights in connection with mental health and psychotherapy reports, pregnancy, HIV/AIDS-related illnesses, and the health treatment of minors.

- Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice upon request. This right applies even if you have previously agreed to accept this Notice electronically. To request a written copy of this Notice at any time, you may write to:

  Pacific Gas and Electric Company
  Plan Administrator — HIPAA
  PG&E Benefits Department
  1850 Gateway Blvd., 7th Floor
  Concord, CA 94520

Changes to this Privacy Notice

The Health Plans reserve the right to change this Notice at any time and from time to time, and to make the revised or changed Notice effective for health information that the Health Plans already have about you, as well as any information that the Health Plans may receive in the future. The revised Notice will be provided to you in the same manner as this Notice, or electronically if you have consented to receive the Notice electronically or you are able to receive electronic information at your worksite, in a manner consistent with federal regulations.

Complaints

If you believe that your health information privacy rights, as described under this Notice, have been violated, you may file a written complaint with the Health Plans by contacting the person listed at the address under "Contact Information," below. You may also file a written complaint directly with the Secretary of the U.S. Department of Health and Human Services, at the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Hubert H. Humphrey Building, Washington, D.C. 20201. The complaint should generally be filed within 180 days of when the act or omission complained of occurred. Note: You will not be penalized or retaliated against for filing a complaint.

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this Notice or by the laws that apply to the Health Plans will be made only with your written authorization. If you authorize the Health Plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Health Plans will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Health Plans will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

To receive more information about the Health Plans' privacy practices or your rights, or if you have any questions about this Notice, please contact the Health Plans at the following address:

Health Plan Name(s)	Pacific Gas and Electric Company Health Care Plan for Active Employees, Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, Pacific Gas and Electric Company Health Care Flexible Spending Account Plan
Contact Person	HIPAA Privacy Official
Address	77 Beale Street, Mail Code B23H, San Francisco, CA 94105
Phone	(415) 973-0290

A copy of this Notice is available online in the **Human Resources Forms** section of the PG&E@Work intranet, or you can contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-4357 or toll-free at 800-788-2363.

Forfeiture of Unclaimed Benefit Payments

If you receive, or are entitled to receive, a benefit payment from one of the self-insured health plans and the Claims Administrator cannot locate you, the payment will be returned to the Company or, if paid from one of the Company's trust funds, the appropriate trust. If, after three years from the date on which the benefit is paid or became payable, you have not accepted the payment or corresponded with the Claims Administrator or Trustee in writing concerning the benefit payment, the payment will be forfeited to the Company's operating general assets or trust that issued the payment. For additional information on plan funding, see "Funding" in the table that describes "The Pacific Gas and Electric Company Health Care Flexible Spending Account Plan" on page 486.

If the Plan Administrator is unable to locate a Participant entitled to benefits payable from the Pacific Gas and Electric Company Retirement Plan ("Retirement Plan") or the PG&E Corporation Retirement Savings Plan for Union-Represented Employees ("RSP") after three years and after reasonable efforts have been made to do so, the Participant's benefit under the Plan will be forfeited and used to offset future employer contributions. If a proper claim is subsequently presented, the Participant's benefit will be reinstated. For additional information, see "Missing Participants" in the section describing the RSP, and "Your Responsibility to Maintain a Current Address" in the section that describes the Retirement Plan.

Facility of Payment

If any benefit from one of the self-insured health plans is payable to the estate of a Participant or to a dependent who is a minor or otherwise not competent to give a valid release, the self-insured health plan may pay the benefits to any relative or other person or persons whom the plan determines to have accepted competent responsibility for the care of the Participant or the dependent or for administration of the Participant's estate. Any payment made by a self-insured health plan in good faith pursuant to this provision fully discharges the plan and the Company to the extent of such payment.

Administrative Information

This section contains administrative details, such as official plan names and numbers and contact information for each plan.

The Health and Welfare Benefits Pre-Tax Plan

Name and Address of Employer	The Pacific Gas and Electric Company Health and Welfare Benefits Pre-Tax 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	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 and Welfare Benefits Pre-Tax Plan
Plan Number	525
Plan Type	Section 125
Plan Year	1/1–12/31
Plan Administrators	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
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 Plans. 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. Service should be directed to: Linda Y. H. Cheng Vice President, Corporate Governance and Corporate Secretary Pacific Gas and Electric Company 77 Beale Street Mail Code B24W San Francisco, CA 94105
Other Administrative Information	The Pacific Gas and Electric Company Health and Welfare Pre-Tax Plan is a "cafeteria" plan under Section 125 of the Internal Revenue Code. This is a non-ERISA Plan.
Funding	The Company is the administrator and pays the actual costs of the Plan directly from the Company's general assets, as the costs are incurred.

The Pacific Gas and Electric Company Health Care Plan for Active Employees

Name and Address of Employer	The Pacific Gas and Electric Company Health Care Plan For Active Employees 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	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 Plan for Active Employees
Plan Number	541
Plan Type	See "Plan Directory" below.
Plan Year	1/1–12/31
Plan Administrators (Referred to collectively as "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 The Plan Administrator for the Plan, with respect to appeals regarding claims decisions only is: The Employee Benefit Appeals Committee (EBAC) of Pacific Gas and Electric Company c/o Benefits Department 1850 Gateway Boulevard, 7th Floor Concord, CA 94520

Plan Trustee, Insurance Issuer and/or Third-Party Administrator	See "Plan Directory" below.
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 Plans. The Plan Administrator has the discretionary authority to interpret, construe, and define the terms of the Plan and may advise the Plans' Claims Administrators of such interpretations, constructions and definitions. Notwithstanding the foregoing, the Employee Assistance Program has the authority to interpret and construe the terms of its contracts and Evidences of Coverage and to resolve claims for benefits. See the row titled "Funding" in this table for additional 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 77 Beale Street Mail Code B24W 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 Plan for Active Employees Plan is a "welfare" plan.
Funding	The Health Account Plan, the Wellness Program, the Vision Plan, the Dental Plan, the Prescription Drug program, the Mental Health and Substance Abuse program, and the Health Account are all "self-insured." This means the Company is responsible for the overall design and administration of the plans and the Company is financially responsible for the payment of the actual costs of the benefit claims. The cost of the benefit claims are paid directly from the Company's general assets, after the claims are incurred. The Employee Assistance Program is insured and is administered by Value Options. Premiums for this insurance coverage are paid by the Company from its general assets. Manufacturer rebates are earned upon participant purchase of certain prescription drugs. The value of these rebates is based on the contract that Pacific Gas and Electric Company, as Plan sponsor, has with Express Scripts. These rebates are received from Express Scripts approximately six months after the purchase of a drug and are deposited back to the trust holding the plan assets for retirees or employees on long-term disability or back to the company for active employees. The cost of the Plan is reduced by the value of the rebates. Employees pay a portion of the costs, generally through pre-tax contributions. The applicable employee contribution is established annually.

Plan Directory

The plan directory includes, in alphabetical order, the programs that make up The Pacific Gas and Electric Company Health Care Plan for Active Employees. The Company contracts with various health care organizations to administer claims for the self-funded health plans. These organizations are called third-party administrators.

Plan Name	Plan Type	Trustee, Insurance Issuer and/or Third-Party Administrator
Anthem Blue Cross Health Account Plan (HAP) **Comprehensive Access Plan (CAP), Network Access Plan (NAP), and Health Savings Account Medical Plan (HSA Medical Plan)**	hospitalization and medical benefits	Third-Party Administrator: Anthem Blue Cross PO Box 60007 Los Angeles, CA 90060-0007
Kaiser Permanente Insurance Company Health Account Plan (HAP) **Kaiser Permanente Exclusive Provider Organization (EPO)**	hospitalization and medical benefits	Third-Party Administrator: KPIC Self-Funded Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547 Payor ID # 94320
Kaiser Permanente Senior Advantage Plan — Northern and Southern Regions	Kaiser Permanente	Kaiser Permanente
Dental Plan	dental benefits	Third-Party Administrator: Delta Dental of California P.O. Box 7736 San Francisco, CA 94120
Employee Assistance Program	assessment and referral benefits	Third-Party Administrator: ValueOptions P. O. Box 6065 Cypress, CA 90630-0065
Mental Health and Substance Abuse Program	hospitalization and medical benefits	Third-Party Administrator: Value Options P. O. Box 6065 Cypress, CA 90630-0065
Prescription Drug Program	prescription drug benefits	Third-Party Administrator: Express Scripts P.O. Box 14711 Lexington, KY 40512
Vision Plan	vision benefits	Third-Party Administrator: Vision Service Plan P. O. Box 997100 Sacramento, CA 95899-7100
Wellness program	health and wellness, including tobacco cessation and health screenings	Thirty Party Administrator: Provant Health Solutions 42 Ladd Street East Greenwich, RI 02818

Plan Name	Plan Type	Trustee, Insurance Issuer and/or Third-Party Administrator
Tuition Refund Program	Employee educational assistance	Thirty Party Administrator: EdLink 350 No. Clark St. #500 Chicago, IL 60654
Health Account	health reimbursement arrangement medical plan	Third-Party Administrator: **For the Anthem HAP:** Pacific Gas and Electric Company Benefits Department, 7th Floor Plan Administrator Appeals 1850 Gateway Boulevard Concord, CA 94520 **For the KPIC HAP:** KPIC Self-Funded Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547 Payor ID # 94320

Note: Several plans are only available to members on Long-Term Disability (LTD). These plans include the Network Access Plan (NAP) and the Comprehensive Access Plan (CAP), administered by Anthem Blue Cross, as well as the KPIC Exclusive Provider Organization (EPO) Plan and Kaiser Senior Advantage. For details about the Anthem NAP or CAP plans or Kaiser Senior Advantage, see "Medical Coverage" in the *Health Care Benefits* section of the 2011 Summary of Benefits Handbook for IBEW-, ESC-, and SEIU-Represented Employees as modified by subsequent Summaries of Material Modifications (e.g., annual open enrollment guides), Evidences of Coverage and insurance policies, or see the most current summary plan description. For details about the Kaiser EPO Plan, please refer to the most current Kaiser Permanente Exclusive Provider Organization Plan Summary of Benefits Handbook.

The Pacific Gas and Electric Company Health Care Flexible Spending Account Plan

Name and Address of Employer	The Pacific Gas and Electric Company Health Care Flexible Spending 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
Participating Employers	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 Flexible Spending Account Plan
Plan Number:	526
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 Flexible Spending Account Plan and the Dependent Care Flexible Spending Account Plan: If you're an Anthem member or have waived PG&E-sponsored medical coverage, send claims to: Your Spending Account (YSA) PO Box 785040 Orlando, FL 32878-5040 If you're a KPIC member, send claims to: Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services PO Box 6000 Fargo, ND 58108-6000
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.
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 77 Beale Street Mail Code B24W 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 Flexible Spending Account Plan is a "welfare" plan.
Funding	The Pacific Gas and Electric Company Health Care Flexible Spending 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 Long-Term Disability Plan

Name and Address of Employer	The Long-Term Disability 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	Pacific Gas and Electric Company
Plan Name	The Pacific Gas and Electric Company Long-Term Disability Plan
Plan Number	503
Plan Type	Income replacement — long-term disability
Plan Year	1/1–12/31
Plan Administrators	The Plan Administrator for the Plan is: The Employee Benefit Committee (EBC) of PG&E Corporation c/o Pacific Gas and Electric Company Long-Term Disability Benefits Department 1850 Gateway Boulevard, 7th Floor Concord, CA 94520
Plan Trustee, Insurance Issuer or Third-Party Administrator	Third-Party Administrator: Matrix Absence Management, Inc. 181 Metro Drive, Suite 300 San Jose, CA 95110 Plan Trustee: the Bank of New York Mellon One Mellon Center 500 Grant Street, Room 1315 Pittsburgh, PA 15258-0001
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. 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. Pacific Gas and Electric Company Long-Term Disability Plan is a “welfare” plan.
Funding	The Long-Term Disability benefit provided under the Pacific Gas and Electric Company Long-Term Disability Plan is self-insured. Long-Term Disability benefits are paid from a trust to which the Company makes contributions.

The PG&E Corporation Disability Plan

Name and Address of Employer	The PG&E Corporation Disability Plan is sponsored by: PG&E Corporation One Market Street, Spear Tower, Suite 2400 San Francisco, CA 94105
Employer Identification Number	The Internal Revenue Service has assigned this ID number to the Plan sponsor: PG&E Corporation: 94-3234914
Participating Employers	PG&E Corporation PG&E Corporation Support Services, Inc. PG&E Corporation Support Services II, Inc. Pacific Gas and Electric Company (but solely with respect to short-term disability benefits provided under the Plan and solely to certain of its employees residing outside of the State of California, as determined from time to time by its Senior Vice President – Human Resources)
Plan Name	PG&E Corporation Disability Plan
Plan Number	503
Plan type	Income replacement — short and long-term disability
Plan Year	1/1–12/31
Plan Administrators	The Plan Administrator for the Plan is: The Employee Benefit Committee (EBC) of PG&E Corporation c/o Pacific Gas and Electric Company Absence and Accommodation Solutions Department 1850 Gateway Boulevard, 7th Floor Concord, CA 94520
Plan Trustee, Insurance Issuer and/or Third Party Administrator	Insurance Issuer: Standard Insurance Company PO Box 2800 Portland OR 97208-2800 Phone 800-368-2859
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. Notwithstanding the foregoing, the insurer has the authority to construe and interpret the terms of the insurance policy, the certificate of insurance or other similar documents which describe the terms and conditions of the disability insurance policy or policies. Nothing in the plan documents or any other communication or document is intended to provide any individual with a substantive right to short or long-term disability benefits that are not provided for in the short and long-term disability insurance policy or policies.

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. Service should be directed to: Linda Y.H. Cheng Vice President, Corporate Governance and Corporate Secretary PG&E Corporation 77 Beale Street Mail Code B24W San Francisco, CA 94105
Other Administrative Information	ERISA divides employee benefit plans into two broad categories: welfare plans and pension plans. Your PG&E Corporation Disability Plan is a "welfare" plan.
Funding	The PG&E Corporation Disability Plan is insured by Standard Insurance Company. Standard Insurance Company (not PG&E Corporation) is responsible for paying benefits. PG&E Corporation and other participating employers pay all premium costs.

The Supplemental Benefits for Industrial Injury Plan

Name and Address of Employer	The Supplemental Benefits for Industrial Injury Plan is sponsored by: Pacific Gas and Electric Company Workers' Compensation Department P.O. Box 7779 San Francisco, CA 94120-7779
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	Pacific Gas and Electric Company
Plan Name	The Supplemental Benefits for Industrial Injury Plan
Plan Number	501
Plan Type	Income Replacement — Disability
Plan Year	1/1–12/31
Plan Administrators	The Plan Administrator for the Plan is: The Employee Benefit Committee (EBC) of PG&E Corporation c/o Pacific Gas and Electric Company Workers' Compensation Department P.O. Box 7779 San Francisco, CA 94120-7779 (415) 973-8700
Claims Administrator	Pacific Gas and Electric Company Workers' Compensation Department P.O. Box 7779 San Francisco, CA 94120-7779 (415) 973-8700

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. Service should be directed to: Linda Y.H. Cheng Vice President, Corporate Governance and Corporate Secretary Pacific Gas and Electric Company 77 Beale Street Mail Code B24W San Francisco, CA 94105
Funding	The Supplemental Benefits for Industrial Injury Plan is self-insured. This means the Company pays the actual cost of the benefit claims directly from the Company's general assets, after the claims are incurred.

The Pacific Gas and Electric Company Group Life Insurance Plan

Name and Address of Employer	The Pacific Gas and Electric Company Group Life Insurance 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	Pacific Gas and Electric Company PG&E Corporation PG&E Corporation Support Services, Inc. PG&E Corporation Support Services II, Inc.
Plan Name	Pacific Gas and Electric Company Group Life Insurance Plan
Plan Number	Group Life and AD&D: 543
Plan Type	Group life and accidental death and dismemberment (AD&D) insurance
Plan Administrators	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	Insurance Issuer: MetLife 425 Market Street, Suite 970 San Francisco, CA 94105-2230

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. Service should be directed to: Linda Y.H. Cheng Vice President, Corporate Governance and Corporate Secretary Pacific Gas and Electric Company 77 Beale Street Mail Code B24W San Francisco, CA 94105
Other Administrative Information	ERISA divides employee benefit plans into two broad categories: welfare plans and pension plans. The Pacific Gas and Electric Company Group Life Insurance Plan is a "welfare" plan.
Funding	The Group Life & AD&D benefits are fully insured through MetLife. The Basic life and Basic AD&D insurance premiums and administrative expenses are paid for by the Company.

The PG&E Corporation Business Travel Insurance Plan

Name and Address of Employer	The PG&E Corporation Business Travel Insurance Plan is sponsored by: PG&E Corporation One Market Street, Spear Tower, Suite 2400 San Francisco, CA 94105
Employer Identification Number	The Internal Revenue Service has assigned this ID number to the Plan sponsor: PG&E Corporation 94-3234914
Participating Employers	Pacific Gas and Electric Company PG&E Corporation PG&E Corporation Support Services, Inc. PG&E Corporation Support Services II, Inc.
Plan Name	PG&E Corporation Business Travel Accident Insurance Plan (BTI)
Plan Number	Business Travel Accident: 502
Plan Type	Group life and accidental death and dismemberment (AD&D) insurance
Plan Administrators	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	Insurance Issuer: Life Insurance Company of North America Two Liberty Place 1601 Chestnut Street Philadelphia, PA 19192-2235
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. Service should be directed to: Linda Y.H. Cheng Vice President, Corporate Governance and Corporate Secretary PG&E Corporation 77 Beale Street Mail Code B24W San Francisco, CA 94105
Other Administrative Information	ERISA divides employee benefit plans into two broad categories: welfare plans and pension plans. The PG&E Corporation Business Travel Accident Insurance Plan is a “welfare” plan.
Funding	The Business Travel Insurance benefit is fully insured through Life Insurance Company of North America (LICNA). The premiums are paid by the Company, and all benefits are paid by the Life Insurance Company of North America.

The Pacific Gas and Electric Company Retirement 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, 7025C 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	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, 7025C Concord, CA 94520 415-973-4537 or 800-788-2363

Plan Trustee, Insurance Issuer and/or Third-Party Administrator	Plan Trustee: The Bank of New York Mellon One Mellon Center 500 Grant Street, room 1315 Pittsburgh, PA 15258-0001 See the row titled "Funding" in this table for more information.
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 the row titled "Plan Trustee, Insurance Issuer and/or Third-Party Administrator" in this table for the address). Service should be directed to: Corporate Secretary Pacific Gas and Electric Company 77 Beale Street, 24th floor Mail Code B24W 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 provides a specific benefit using a formula; the amount of your benefit depends among other things, upon your pay and your credited service with the Company. 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.
Collective Bargaining Agreement	The Plan is maintained pursuant to multiple collective bargaining agreements. A copy of the agreements may be obtained by respective members and beneficiaries upon written request to: Human Resources – Labor Relations 375 N. Wiget Lane Walnut Creek, CA 94598

PG&E Corporation Retirement Savings Plan for Union-Represented Employees (formerly called the Pacific Gas and Electric Company Savings Fund Plan for Union-Represented Employees)

Name and Address of Employer	The PG&E Corporation Retirement Savings Plan for Union-Represented Employees is sponsored by: PG&E Corporation 1850 Gateway Boulevard, 7025C Concord, CA 94520
Employer Identification Number	The Internal Revenue Service has assigned this ID number to the Plan sponsor: PG&E Corporation: 94-3234914
Participating Employers	Any affiliate or subsidiary of PG&E Corporation which participates in the Plan, including: ▪ PG&E Corporation ▪ Pacific Gas and Electric Company ▪ PG&E Corporation Support Services, Inc. ▪ PG&E Corporation Support Services II, Inc.
Plan Name	PG&E Corporation Retirement Savings Plan for Union-Represented Employees
Plan Number	002
Plan Type	Defined contribution stock bonus plan with an employee stock-ownership plan component and a cash or deferred arrangement designed to qualify under section 401(k) of the Internal Revenue Code (IRC) and meet ERISA section 404(c).
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 PG&E Corporation 1850 Gateway Boulevard, 7025C Concord, CA 94520 415-973-4537 or 800-788-2363
Plan Trustee, Insurance Issuer and/or Third-Party Administrator	Plan Trustee: Fidelity Management Trust Company c/o Administrative Team for PG&E Corporation Retirement Savings Plan for Union-Represented Employees Fidelity Investments 82 Devonshire Street Boston, MA 02109
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 the row titled "Plan Trustee, Insurance Issuer and/or Third-Party Administrator" in this table for the address). Service should be directed to: Corporate Secretary PG&E Corporation 77 Beale Street, 24th floor Mail Code B24W 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 provides a specific benefit using a formula; the amount of your benefit depends among other things, upon your pay and your credited service with the Company. 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 Savings Plan for Union-Represented Employees is a defined contribution plan.
Funding	The Retirement Savings Plan for Union-Represented Employees offers eligible employees a tax-advantaged way to save for retirement. The Plan also includes an Employee Stock Ownership Plan. The Plan is intended to qualify under §401(a) and §401(k) of the Internal Revenue Code. The Plan is also intended to satisfy the requirements of §404(c) of the Employee Retirement Income Security Act of 1974. Employees who want to participate in the Plan may contribute a portion of their salary to the Plan on a pre-tax basis, an after-tax basis, or a combination of both. When an eligible employee elects to make contributions to the Plan, certain participant contributions are eligible for matching employer contributions.
Collective Bargaining Agreement	The Plan is maintained pursuant to multiple collective bargaining agreements. A copy of the agreements may be obtained by respective members and beneficiaries upon written request to: Human Resources – Labor Relations 375 N. Wiget Lane Walnut Creek, CA 94598

The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents

Administrative Information	See the *Rules, Regulations & Administrative Information* section of the Summary of Benefits Handbook For Retirees and Surviving Dependents available on www.mypgebenefits.com.

The Pacific Gas and Electric Company Postretirement Life Insurance Plan

Administrative Information	See the *Rules, Regulations & Administrative Information* section of the Summary of Benefits Handbook For Retirees and Surviving Dependents available on www.mypgebenefits.com.

The Pacific Gas and Electric Company Children's Center Program

Name and Address of Employer	The Pacific Gas and Electric Company Children's Center Program 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	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 Children's Center Program
Plan Number	540
Plan Type	Child Day Care Services
Plan Year	1/1–12/31
Plan Administrators	The ERISA 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	Third-Party Administrator: Bright Horizons Family Solutions 200 Talcott Avenue South Watertown, Massachusetts 02472 (617) 673-8000
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. Service should be directed to: Linda Y.H. Cheng Vice President, Corporate Governance and Corporate Secretary Pacific Gas and Electric Company 77 Beale Street Mail Code B24W 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 Children's Center Program is a "welfare" plan.
Funding	The Children's Center Program expenses are paid by the Company. The Company pays a portion of the actual costs of the benefits and administrative fees directly from the Company's general assets. Participants pay the remaining costs of the benefits and administrative fees.

The Tuition Refund Program

Name and Address of Employer	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	Pacific Gas and Electric Company PG&E Corporation PG&E Corporation Support Services, Inc. PG&E Corporation Support Services II, Inc.
Plan Name	The Tuition Refund Program
Plan Type	Employee Educational Assistance
Plan Year	1/1–12/31
Plan Administrators	The Plan Administrator for the Plan is: EdLink 350 No. Clark St. #500 Chicago, IL 60654
Discretionary Authority	The Plan Administrator has oversight responsibility for the administration of the Plan which includes maintaining records, and executing business rules as dictated by PG&E Human Resources via the PG&E Tuition Refund Program. They make decisions that may be necessary for administration of the Plan. The Plan Administrator has the discretionary authority to interpret, and execute the plan.

Contacts

This section provides addresses, group numbers, phone numbers, and website addresses so you can contact the organizations that manage or administer the benefit plans.

If You Have Questions

If you have any questions about your benefit options, dependent eligibility or any other benefits, you can send an email to the HR Service Center at hrbenefitsquestions@exchange.pge.com, or you can contact the HR Service Center at Company extension 8-223-4357, externally at 415-973-HELP or toll-free at 800-788-2363.

Plan	Group No.	Phone No.	Web Site	Address
PG&E Self-Funded Plan **Administered by Anthem Blue Cross** *Health Account Plan (HAP)*	PZG170157	800-964-0530 Hours: 7 a.m. – 8 p.m. Pacific time M – F	www.anthem.com/ca/pge	Anthem Blue Cross P.O Box 60007 Los Angeles, CA 90060-0007
PG&E Self-Funded Plan **Administered by Kaiser Permanente Insurance Company** *Health Account Plan (HAP), including prescription drug coverage*	**North** Utility: 603702-7 Corporation: 603702-8 **South** Utility: 231142-7 Corporation: 231142-8	North: 800-663-1771 South: 800-533-1833 Hours: 7 a.m. – 7 p.m. Pacific time M – F 7 a.m. – 3 p.m. Pacific time Saturdays and Sundays	www.my.kp.org/ca/pge	KPIC Self-Funding Claims Administrator P. O. Box 30547 Salt Lake City, UT 84130-0547
Tax-Advantaged Accounts Administered by Your Spending Account (YSA): *Health Account* *Health Care Flexible Spending Account (HCFSA)* *Dependent Care Flexible Spending Account (DCFSA)*	None	800-964-9902 Hours: 5 a.m. – 5 p.m. Pacific time M – F	www.yourspendingaccount.com (general information) www.yourspendingaccount.com/pge (personalized portal)	Your Spending Account (YSA) P.O. Box 785040 Orlando, FL 32878-5040

Plan	Group No.	Phone No.	Web Site	Address
Tax-Advantaged Accounts Administered by Kaiser Permanente Insurance Company Health Payment Services: *Health Account* *Health Care Flexible Spending Account (HCFSA)* *Dependent Care Flexible Spending Account (DCFSA)*	None	877-750-3399 Hours: 5 a.m. – 7 p.m. Pacific time M – F	www.my.kp.org/ca/pge	Kaiser Foundation Health Plan Inc. SF C/O Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540
Prescription Drug Program Administered by Express Scripts *For HAP administered by Anthem Blue Cross*	PGE0000	800-718-6590 Hours: 24 hours a day/7 days a week year-round, except Thanksgiving and Christmas Day	www.express-scripts.com	Express Scripts P. O. Box 14711 Lexington, KY 40512
Mental Health and Substance Abuse Program Administered by ValueOptions *For HAP administered by Anthem Blue Cross and HAP administered by Kaiser Permanente Insurance Company*	None	800-562-3588 Hours: 24 hours a day/7 days a week	www.valueoptions.com	ValueOptions, Inc. P.O. Box 1290 Latham, NY 12110
Dental Plan Administered by Delta Dental	IBEW and SEIU:1515-0101 ESC:1515-0106 LTD: 1515-0111	888-217-5323 Hours: 5 a.m. – 5 p.m. Pacific time M – F	www.deltadentalins.com/pg&e	Delta Dental of California P.O. Box 997330 Sacramento, CA 95899-7330

Plan	Group No.	Phone No.	Web Site	Address
Vision Plan Administered by Vision Service Plan	Union: 00401601-Div 115, Class 3 LTD Union: 00401601-Div 117, Class 8	800-877-7195 Hours: 5 a.m. – 8 p.m. Pacific time M – F 6 a.m. – 5 p.m. Pacific time Saturday	www.vsp.com	Vision Service Plan Customer Service Department 3333 Quality Drive Rancho Cordova, CA 95670
Retirement Savings Plan — 401(k) Administered by Fidelity	Plan No.: 001 EIN: 94-3234914	877-743-4015 Hours: 5:30 a.m. – 9 p.m. Pacific time M – F	www.401k.com	
Financial Engines	Plan No.: 001 EIN: 94-3234914	877-743-4015 (ask for Financial Engines) Hours: 6 a.m. – 6 p.m. Pacific time M – F	www.401k.com (click the Financial Engines link)	
Retirement Plan — Pension Administered by Xerox	Plan No.: 001 EIN: 94-0742640	800-788-2363 or 415-973-4357 (ask for Retirement) Hours: 7:30 a.m. – 5 p.m. Pacific time M – F	https://pgepensioncenter.com	Email: hrbenefitsquestions@exchange.pge.com
Health Care Plan for Retirees and Surviving Dependents – Retiree Medical Savings Account (RMSA) Administered by Xerox	Plan No.: 535 EIN: 94-0742640	800-788-2363 or 415-973-4357 (ask for Retirement) Hours: 7:30 a.m. – 5 p.m. Pacific time M – F	https://pgepensioncenter.com	Email: hrbenefitsquestions@exchange.pge.com

Plan	Group No.	Phone No.	Web Site	Address
COBRA Administered by Ceridian	None	800-877-7994 Hours: 5 a.m. – 5 p.m. Pacific time M – F	www.ceridian-benefits.com	Ceridian (COBRASERV) P.O. Box 534099 St. Petersburg, FL 33747-4099
Provant	None	866-271-8144 Hours: 5 a.m. – 5 p.m. Pacific time M – F	https://www.pge.provantonline.com	Provant Health Solutions, LLC. 42 Ladd St # 214 East Greenwich, RI 02818
Employee Assistance Program Administered by ValueOptions	None	888-445-4436 Hours: 24 hours a day/ 7 days a week	PG&E Intranet http://pgeweb/services/Pages/EmployeeAssistanceProgram.aspx or Internet: www.achievesolutions.net/pge	ValueOptions, Inc. P.O. Box 1290 Latham, NY 12110
PG&E Leave Management	None	866-369-7582 Hours: Case Managers available 5 a.m. – 5 p.m. Pacific time M – F Limited after-hours assistance available 24 hours a day/7 days a week	PG&E Intranet only http://pgeweb/services/Pages/LeaveOfAbsence.aspx	Aon Hewitt P.O. Box 1548 Farmington, CT 06034-1548
PG&E Long-Term Disability	Plan No.: 503 Utility EIN: 94-0742640	888-445-4462 Hours: 8 a.m. – 5 p.m. Pacific time M – F	PG&E Intranet only http://pgeweb/services/Pages/DisabilityForUtilityEmployees.aspx	Matrix Absence Management, Inc. P.O. Box 11035 San Jose, CA 95103

Plan	Group No.	Phone No.	Web Site	Address
Group Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance Administered by MetLife	74300	888-878-8490 Hours: 5 a.m. – 8 p.m. Pacific time M – F Fax: 866-545-7517	https://mybenefits.metlife.com/pg&e	Met Life Recordkeeping Center P.O. Box 14401 Lexington, KY 40512-4401
Travel Assistance and Identity Theft Program Administered by AXA Assistance	74300	800-454-3679 (inside US) 312-935-3783 (outside US) Hours: 24 hours a day/ 7 days a week	http://webcorp.axa-assistance.com/ User Name: axa Password: travelassist	
Will Preparation and Estate Resolution Services Administered by Hyatt Legal Plans	74300	800-821-6400 Hours: 5 a.m. – 4 p.m. Pacific time M – F	www.legalplans.com	
Tuition Refund Program Administered by EdLink	Utility Standard: HR-1101S	888-718-2235 7 a.m. - 3 p.m. Pacific time M-F	PGE Intranet only http://pgeweb/services/Pages/ServiceDetails.aspx	350 No. Clark Street #500 Chicago, IL 60654 Email: PGETuition@edlinktuition.com

Description of the PG&E Corporation Stock Fund
Offered Through
The PG&E Corporation Retirement Savings Plan
and
The PG&E Corporation Retirement Savings Plan for Union-Represented Employees

June 1, 2013

This document constitutes part of a prospectus covering securities that have been registered under the Securities Act of 1933.

Introduction

This document describes the PG&E Corporation Stock Fund, an investment fund offered to participants in the PG&E Corporation Retirement Savings Plan and the PG&E Corporation Retirement Savings Plan for Union-Represented Employees (the "Plans"). The Plans offer eligible employees of PG&E Corporation, its subsidiary, Pacific Gas and Electric Company, and other affiliated subsidiaries, a tax-advantaged way to save for retirement. The Plans are intended to qualify under §401(a) of the Internal Revenue Code. The Plans are also intended to satisfy the requirements of §404(c) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), including all applicable regulations issued by the United States Department of Labor and the United States Treasury Department. Participants in the Plans are entitled to certain rights and protections under ERISA, as described in the summary plan descriptions.

The assets of the Plans are held under a master trust maintained by Fidelity Management Trust Company ("Fidelity"). PG&E Corporation Employee Benefit Committee, the Plan Administrator of the Plan, has prepared a summary plan description, dated January 1, 2013, for each Plan that contains information about the respective Plan. These summary plan descriptions are incorporated by reference into this document as if the terms of each summary plan description were contained in this document. If there is any inconsistency or conflict between the summary plan descriptions and this document, the provisions of the summary plan descriptions shall control.

Participants in the Plans have a number of investment options for building individual investment portfolios to achieve their retirement savings goals. As described in the summary plan descriptions, participants' investment options are structured in three tiers:

- Tier 1: Target Date Funds
- Tier 2: Core Funds
- Tier 3: Self-Directed Account (Fidelity BrokerageLink)

Investment information, including the descriptions of the Tier 1 and Tier 2 funds, and investment performance for each fund, can be found by logging on to Fidelity NetBenefits℠ online account services at www.401k.com or by calling Fidelity's RSP Service Center at 1-877-PGE-401K (1-877-743-4015). The fund description and information regarding investment performance for each Tier 1 and Tier 2 fund, including the fund description of the PG&E Corporation Stock Fund, are incorporated by reference into this document. In order to participate in Tier 3, the self-directed account, participants must first establish a Fidelity BrokerageLink account. Information regarding the investments available through a participant's Fidelity BrokerageLink account is available through Fidelity BrokerageLink.

The PG&E Corporation Stock Fund

The PG&E Corporation Stock Fund (the "Fund") is an investment fund within the Tier 2: Core Funds. The Fund is designed to provide participants the opportunity to invest in PG&E Corporation common stock. PG&E Corporation common stock is listed on the New York Stock Exchange ("NYSE") and trades under the symbol "PCG." On May 31, 2013, the closing price of a share of PG&E Corporation common stock on the NYSE was $44.91. The Fund primarily holds PG&E Corporation common stock, along with a small amount of short-term investments that is held to provide the liquidity needed to accommodate participants' buy and sell orders on a daily basis. All matching employer contributions, as described in the summary plan description for each plan, are initially invested in the Fund. More information about applicable fees and investment performance appears in description of the Fund referred to above.

Under the accounting method used for the Fund, each participant owns units of the Fund rather than shares of stock. Each unit represents a proportionate interest in the PG&E Corporation common stock held by the Fund as well as a small amount of the Fund's short-term investments. Each day the value of a Fund unit is adjusted to reflect the change in the NYSE closing price of a share of PG&E Corporation common stock, any dividend activity, and the amount earned on the Fund's short-term investments. As described below, dividends on PG&E Corporation common stock can be paid directly to Fund participants or can be used to purchase additional Fund units. (See "Dividends on PG&E Corporation Common Stock" below).

The Fund is not diversified and effectively invests in a single security. As a result, the Fund's returns will be driven principally by the performance of PG&E Corporation common stock. The Department of Labor and the Internal

Revenue Service advise that if you invest more than 20% of your retirement savings in any one company or industry, such as the PG&E Corporation Stock Fund, your savings may not be properly diversified. Although diversification is not a guarantee against loss, it is an effective strategy to help you manage investment risk. Be sure to review this document and the documents incorporated by reference, including the Fund description, for more information before making your investment decision.

As of June 1, 2013, 21,336,513 shares of PG&E Corporation common stock remained available for offer and sale under the Plans. The shares available for offer and sale in the Fund can be shares that are newly issued by PG&E Corporation or shares purchased on the open market by Fidelity, as the trustee of the Fund, as directed from time to time (but not more frequently than once in any three-month period) by the PG&E Corporation Employee Benefit Plan Committee.

Dividends on PG&E Corporation Common Stock

Participants who hold units in the Fund on the record date for the payment of a dividend on PG&E Corporation common stock may elect to:

- Reinvest the dividends in additional units in the Fund,
- Receive the dividends in cash, or
- Choose a combination of both.

Unless participants instruct Fidelity to pay the dividends in cash, dividends will be reinvested in additional units of the Fund. Once made, this election remains in effect until changed. Participants may change their dividend election each quarter. Dividends are payable only with respect to an investment in the Fund made at least 3 business days before the dividend record date.

Dividend Reinvestment. Participants do not need to do anything to have all of their dividends reinvested.

Dividends Paid in Cash. If a participant would like to receive all or a portion of their dividends in cash, the participant must notify Fidelity at least 11 business days before dividends are paid, excluding NYSE holidays. Participants may specify the portion of dividends to be paid in cash in 1% increments. To make a dividend election, participants must call Fidelity's RSP Service Center at 1-877-PGE-401K (1-877-743-4015).

Taxes. Dividends that are reinvested in additional units of the Fund are not taxed until withdrawn. Dividends that a participant has elected to receive in cash are subject to federal and state income taxes in the year in which the dividends were paid. (The provisions of federal or state law regarding penalty taxes on early distributions from defined contribution plans will not apply to the receipt of cash dividends.)

Voting Rights

Participants who hold Fund units will have the right to vote the proportionate shares of PG&E Corporation common stock held in the Fund that are credited to their account as of the record date for the meeting of PG&E Corporation shareholders. The trustee will send participants the proxy solicitation material issued by PG&E Corporation along with a form to be completed by participants and returned to the trustee to provide confidential voting instructions to the trustee.

Monitoring and Making Changes to Your Investments

Because participants' investment objectives and financial needs change over time, it is important that participants have the flexibility and tools to review their account activity and modify their investments periodically.

You may log onto Fidelity NetBenefits℠ at www.401k.com or contact Fidelity's RSP Service Center by calling 1-877-PGE-401K (1-877-743-4015) to transfer (exchange) money you have accumulated in the Plan among the various Tier 1 and Tier 2 investment fund options, including the PG&E Corporation Stock Fund. Before initiating an

exchange, it is recommended that you carefully review the relevant investment fund descriptions to understand the investment fund characteristics, investment performance, and any restrictions on the frequency of exchanges.

Although matching employer contributions are automatically invested in the PG&E Corporation Stock Fund, participants may reallocate matching employer contributions and accumulated earnings thereon to another investment fund or funds. Participants may also reallocate employee contributions and accumulated earnings thereon that are invested in another investment fund to the PG&E Corporation Stock Fund.

Fidelity will process requests to sell PG&E Corporation Stock Fund units for exchanges, withdrawals, distributions, and loans provided that there are enough short-term investments in the Fund for liquidity. In the unusual event that there are not enough short-term investments for liquidity, requests to sell units will be suspended. As long as the PG&E Corporation Stock Fund remains open and participants have not cancelled the transaction, their requests to sell units will be processed, generally on a first-in-first-out basis, as liquidity is restored in the Fund. Loans and withdrawals will be given priority over exchanges. If a transaction involves a suspended sale of PG&E Corporation Stock Fund units, the entire transaction will be suspended, including the corresponding purchase transaction. Participants will receive the net asset value on the processing date.

Participants who have requested transactions requiring the sale of PG&E Corporation Stock Fund units will need to check their account the following business day to determine whether their request has been processed.

Withdrawals of PG&E Corporation Stock

For any withdrawal of contributions and earnings invested in the PG&E Corporation Stock Fund, participants may have the total amount converted to whole shares of PG&E Corporation common stock or the withdrawal may be paid in cash. A participant who withdraws PG&E Corporation common stock from the Fund will be liable for income taxes on the cost basis of each Fund unit. The cost basis is the average purchase price for all of the participant's units. If the participant later sells the withdrawn shares the participant will be liable for income taxes on the difference between the cost basis of the units and the sale price. The income will be subject to the capital gains tax rate if the participant held the shares for at least one year before sale.

Federal Securities Laws

Trades out of or into the PG&E Corporation Stock Fund (as well as the sale of shares of PG&E Corporation common stock withdrawn from the Fund) are subject to the prohibition against insider trading. If you are aware of "inside" information (i.e., information that would be important to an investor, but which has not yet been made public), you are prohibited by federal securities laws and PG&E Corporation's Insider Trading Policy from trading in the PG&E Corporation Stock Fund (and from selling the withdrawn shares) until the information has been publicly disseminated.

Under the Federal securities laws, Plan participants who are deemed to be "affiliates" of PG&E Corporation may not sell shares of PCG common stock acquired under the Plan unless such shares are registered under the Securities Act of 1933, as amended, for the purpose of such sale or are sold pursuant to an exemption from registration. Rule 405 under the 1933 Act defines "affiliates" as persons who, directly or indirectly, through one or more intermediaries, control or are controlled by, or are under common control with, an issuer of securities. Participants who are considered "affiliates" of PG&E Corporation may generally resell their shares of PG&E Corporation common stock in compliance with Securities and Exchange Commission Rule 144. Plan participants who are not affiliates generally may reoffer or resell shares of PCG common stock acquired under the Plan without restriction.

Executive officers of PG&E Corporation are subject to additional restrictions with respect to transactions involving PG&E Corporation common stock, including transactions in the PG&E Corporation Stock Fund, in order to ensure compliance with Section 16 of the Securities Exchange Act of 1934 ("Exchange Act").

Direct Rollovers

Although an in-kind distribution of PG&E Corporation common stock may be an eligible rollover distribution from the Plans, some IRAs and qualified retirement plans may not accept rollovers of stock certificates. Before requesting a direct rollover of stock certificates, you must verify with the recipient IRA trustee or plan administrator that the IRA or plan will accept a direct rollover of stock certificates.

Incorporation of Certain Documents by Reference

PG&E Corporation files annual, quarterly, and current reports, information statements and other information with the Securities and Exchange Commission ("SEC"). These SEC filings are available to the public over the Internet at the SEC's website at www.sec.gov. You may also read and copy any of these SEC filings at the SEC's public reference room at 100 F Street NE, Room 1580, Washington, DC 20549. Please call the SEC at 1-800-SEC-0330 for further information on its public reference room. The documents filed by PG&E Corporation with the SEC are also available on PG&E Corporation's website at www.pgecorp.com under the "Investors" tab.

PG&E Corporation has filed a registration statement with the SEC relating to the offer and sale of PG&E Corporation common stock under the Plans through participants' investments in the Fund. The registration statement also covers the offer and sale of an indeterminate number of participant interests in the Plans. Certain documents that PG&E Corporation and the Plans have filed with the SEC are incorporated by reference into the registration statement and into this description of the PG&E Corporation Stock Fund, including:

- PG&E Corporation's latest annual report on Form 10-K filed pursuant to Section 13(a) of the Exchange Act;
- All other reports filed by PG&E Corporation pursuant to the Exchange Act since the end of the fiscal year covered by PG&E Corporation's latest annual report on Form 10-K;
- The latest annual report on Form 11-K filed by the Plans; and
- The description of PG&E Corporation's common stock in PG&E Corporation's Registration Statement on Form 8-B dated December 23, 1996, including any amendment or report filed for the purpose of updating such description.

In addition, certain reports and documents that PG&E Corporation and the Plans will file in the future with the SEC under Section 13(a) or Section 14 of the Exchange Act before the filing of a post-effective amendment to the registration statement, which indicates that all securities offered thereunder have been sold, or which deregisters all securities then remaining unsold, will be incorporated by reference into the registration statement and this description of the PG&E Corporation Stock Fund and will be deemed to be a part thereof as of the date such documents and reports are filed with the SEC.

Copies of the documents incorporated by reference, as well as copies of PG&E Corporation's latest annual report to shareholders and other communications sent to shareholders, are available without charge upon oral or written request to:

PG&E Corporation
Corporate Secretary
77 Beale Street, 24th floor
Mail Code B24W
San Francisco, CA 94105