Summary Material Modification to the Summary of Benefits Handbook

Management and Administrative & Technical Employees

This booklet describes important changes to your health care plans that are effective in 2009. This document is being provided to you as a supplement to the Open Enrollment materials that were sent to you in the fall of 2008 and also as an update, or "Summary of Material Modifications," to your *2008 Summary of Benefits Handbook*. Please keep this information for future reference.

Questions? Send your questions by e-mail to *HRBenefitsquestions@exchange.pge.com* or call the HR Service Center at 415-973-4357 or 1-800-788-2363. PG&E's *Summary of Benefits Handbook* is available on the PG&E HR intranet site under **Plans, Policies & Forms > Benefit Plan Documents**, or you can request a paper or CD-ROM copy free of charge by calling the HR Service Center.

2009
Summary of Material Modifications

Management and Administrative & Technical Employees

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Wellness Account

The Wellness Account offers you a way to earn incentive credits when you participate in health and wellness programs.

Summary of Material Modifications

This Wellness Account section of the booklet constitutes a Summary of Material Modifications to the Pacific Gas and Electric Company Health Care Plan for Active Employees ("Plan"), effective January 1, 2009.

In addition to being a Summary of Material Modifications, this Wellness Accounts section of the booklet:

- is a new subsection of Section B – Health Care Benefits of the Summary of Benefits Handbook for Management and Administrative & Technical Employees ("Handbook"), and
- adds information under Subsection B-VIII of Section B – Health Care Benefits of the Handbook (see ERISA INFORMATION in this section of the booklet).

Unless otherwise noted, when reference is made to a different topic or section, the reference is to the Summary of Benefits Handbook for Management and Administrative & Technical Employees Handbook, not this booklet.

Pacific Gas and Electric Company has the right to amend or terminate the Plan at any time and for any reason. Generally, an amendment to or termination of the plans will apply prospectively and will affect your rights and obligations under the Plan prospectively.

Summary of Benefits

The IRS allows you to pay for certain health care services with incentive credits through your Wellness Account (which is legally considered a Health Reimbursement Arrangement medical plan by the IRS). This means that certain health care services can actually cost you less. You can enjoy this tax advantage by participating and completing specific wellness account activities, as offered each year.

If you are an active Management or Administrative & Technical employee, and you and your spouse or registered domestic partner are enrolled in a PG&E-sponsored medical plan, you each are eligible to earn incentive credits for a Wellness Account. Because the Wellness Account is part of the PG&E-sponsored medical plan for active employees, 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 MID-YEAR ENROLLMENT CHANGES AND CHANGE-IN-STATUS EVENTS under ENROLLMENT in the FLEX PLAN section of the Handbook). You are eligible for a Wellness Account when you enroll in a PG&E-sponsored medical plan and your Wellness Account becomes active when you participate and complete a Wellness Account activity.

ConnectYourCare (Claims Administrator) is the third-party administrator for the Wellness Account, the Health Care Reimbursement Account (HCRA) and the Dependent Care Reimbursement Account. If you have any questions about the Wellness Account, IRS rules, or your claims, you may contact ConnectYourCare at 1-888-439-5121 or *www.connectyourcare.com*. Representatives are available 24 hours a day, seven days a week.

You are not eligible for Wellness Account benefits if you are on long-term disability, a union-represented employee, an intern, contract or agency worker, hiring hall employee, or retired employee.

Although the Wellness Account sounds similar to the Health Care Reimbursement Account, they are different types of plans (see HEALTH CARE REIMBURSEMENT ACCOUNT in the REIMBURSEMENT ACCOUNTS section of the Handbook).

The Company[1] may treat part or all of your reimbursements or Wellness Account credits as taxable income to comply with applicable laws and regulations. You will be notified if your Wellness Account is affected.

How the Wellness Account Works

Eligibility

If you are an active Management or Administrative & Technical employee who is enrolled in a PG&E-sponsored medical plan, you and your enrolled spouse or registered domestic partner are eligible to earn credits for the Wellness Account. If you terminate your PG&E-sponsored medical plan coverage for active Management and Administrative & Technical employees (for example, you transfer to a union-represented employee position, leave the Company, drop coverage or retire), you will no longer be eligible for the Wellness Account and will forfeit any balances in the account. To continue in a PG&E-sponsored medical plan, after you, for example, terminate employment, see COBRA COVERAGE in the COBRA AND CONVERSION TO AN INDIVIDUAL MEDICAL POLICY section of the Handbook.

Management and Administrative & Technical employees who are on long-term disability are not eligible for Wellness Account credits, even though they may be enrolled in a PG&E-sponsored medical plan.

[1] Throughout this section, unless otherwise stated, reference to the "Company" or "PG&E" means Pacific Gas and Electric Company. The plans and benefits described in this handbook are also applicable to employees of PG&E Corporation and its designated subsidiaries, 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.

Company Credits and Your Wellness Account

The Company will credit your account with a specific credit amount once you, your spouse or registered domestic partner has completed a wellness activity. It may take up to six weeks for a credit to be reflected in your Wellness Account.

You may not contribute to the Wellness Accounts by making deposits to your Wellness 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 most 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 Wellness Account

Your Wellness Account will be established when you, your spouse or registered domestic partner participate and complete specific wellness account activities, as offered each year by the Company. When you are enrolled in a PG&E-sponsored medical plan, you can earn credits at any time during each year for being proactive about your health. Credits are not prorated.

Effective January 1, 2009, you can take the Health Risk Questionnaire (HRQ) offered and administered through your PG&E-sponsored medical plan. The purpose of the HRQ 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. You can earn an annual $200 credit for completing a HRQ offered through a PG&E-sponsored medical plan at any time during the year. In addition, if your spouse or registered domestic partner is covered under your PG&E-sponsored medical plan and takes a HRQ offered through a PG&E-sponsored medical plan, he or she can earn an annual $200 credit. You and your spouse or registered domestic partner are each only eligible for one annual HRQ credit even when there may be a change in medical plan coverage during the year.

PG&E will see summary or combined HRQ data from the medical plans to understand overall health trends and areas that may need attention in our health and wellness programs. Identifying data, such as your individual responses, will not be shared with PG&E.

You can access the online questionnaire through your medical plan's website:

www.blueshieldca.com/pge

www.anthem.com/ca/pge

www.my.kaiserpermanente.org/ca/pge

www.healthnet.com/pge

Incentive credits you earn by taking the HRQ will be credited to your Wellness Account, but the Wellness Account is not funded. All reimbursements of eligible expenses are made from the Company's general assets.

Setting Up Your Wellness Account

A Wellness Activity must first be completed in order for you to set up an account and to obtain reimbursements for eligible health care claims from the Wellness Account.

Log in to your Wellness Account. Go to *www.connectyourcare.com*. Select the log-in link from the upper right hand corner. Choose New User Registration to select 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 balance is available at any time online, or over the phone.

For more information, contact ConnectYourCare at 1-888-439-5121 or *www.connectyourcare.com*. Representatives are available 24 hours a day, seven days a week.

Reimbursement of Eligible Health Care Expenses

You can use the money in your Wellness 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 money from your Wellness Account.

If you are covered under both the Health Care Reimbursement Account (HCRA) and the Wellness Account, you will have a combined healthcare payment card. The card is programmed to deduct money first from your HCRA, since the health care reimbursement account is a "use it or lose it" program, while funds in your Wellness Account can be used in future years, as long as you remain an eligible participant. (See MORE ABOUT REIMBURSEMENT ACCOUNTS in this booklet for more information.)

There are two ways to pay for eligible health care expenses:

Approach One: Use Your Healthcare Payment Card.

1. ConnectYourCare will automatically send you a healthcare payment card that you can use to pay for eligible expenses at a qualified merchant.

   Your healthcare payment card works in a fashion similar to a debit card. You can use it to pay copayments at the doctor's office, coinsurance for your prescription drugs, procedures allowed by the IRS but not covered by insurance and other similar transactions. The card has a swipe feature as well as a dedicated card number.

   The card can be used to access the total value of your HCRA. However, it can only be used for merchants that have been deemed as healthcare merchants. Examples of qualified merchants may include pharmacies, doctors' offices, vision centers, and hospitals. Your payment card will automatically be activated the first time you use it.

2. Be sure to keep your itemized receipts as documentation. Although your healthcare payment card eliminates the need to file paper claims, your charges must be verified. **Always keep your receipts for tax purposes, in case ConnectYourCare needs a receipt, or the IRS requests them to confirm a purchase**. ConnectYourCare will notify you within approximately a week from the date of your healthcare payment card swipe, if a receipt is needed. If ConnectYourCare has your e-mail information, notification will be electronic. Otherwise, it will be by mail.

3. If you use the healthcare payment card for an ineligible expense or for one that ConnectYourCare does not have proper documentation, you will be required to reimburse the account for the amount of that transaction.

4. If you need to order a replacement or additional healthcare payment card, you can log in to your online account or call ConnectYourCare at 1-888-439-5121 to request another card. Be sure to call ConnectYourCare as well if your card is lost or stolen.

Details on how to use your healthcare payment card, more information about how to submit expenses and which merchants accept the payment card is available at *www.connectyourcare.com* or by calling ConnectYourCare at 1-888-439-5121.

Approach Two: Pay for the Expense and File a Claim

You can also pay for out-of-pocket expenses using your own personal credit card, cash or check, and keep your itemized receipt as documentation. Then, log in to your online account to file for reimbursement. 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. **Log in to your FSA Account.** Go to *www.connectyourcare.com*. Select the log-in link from the upper right hand corner. Choose New User Registration to select your username and password. 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.

   To file a claim online:

   1. Log in to your online account and select Claim Center from the main menu across the top of the screen.
   2. Click on Add New Claim from the left-hand menu.
   3. Follow the four easy steps on the screen to enter information about your claim.
   4. Print your cover sheet and then send it by fax or e-mail (as a .tif or .pdf file) with your receipts to the number/e-mail address shown on the form.

   If you need help determining which of your expenses are eligible, you should contact ConnectYourCare. Eligibility for reimbursement is based on when services are actually received, regardless of when you pay for such expenses. For additional information, see ELIGIBLE EXPENSES under the HEALTH CARE REIMBURSEMENT ACCOUNT in this booklet.
4. **Print and mail the completed claim submission form,** along with original invoices and any applicable explanation of benefits (EOBs) or health plan website claims print-outs to 307 International Circle, Suite 200 Hunt Valley, MD 21030. Be sure to keep a photocopy of everything for yourself before you submit it to the ConnectYourCare processing center. Or you may fax your completed claims submission form and a copy of the original invoices to 1-866-879-0812.

5. **Processing of 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 by signing up at *www.connectyourcare.com*. If you chose automatic bank account deposits for your reimbursement accounts for a calendar year, the election will automatically roll over when you re-enroll in the Plan for the new calendar year.

Any money left in your account(s) which is not used to reimburse yourself for eligible expenses will carry forward to the next Plan year. There is a three-month "run-out" period that ends March 31 of the following Plan year during which you can submit claims for eligible services rendered in the prior year.

Availability of Wellness Account Credits for Reimbursement

For Wellness Account claims, you, your spouse or registered domestic partner must first complete a Wellness Activity in order for your Wellness Account to be established and for the claim to be reimbursed. For example, you and your spouse or registered domestic partner are enrolled in a PG&E-sponsored medical plan as of January 1, 2009. On June 15, 2009, you complete an HRQ on your medical plan vendor's website. You are not participating in the Health Care Reimbursement Account and visit the doctor and incur an expense for an office visit co-payment on October 1, 2009. The office visit co-payment amount is an eligible health care expense that can be reimbursed from your Wellness Account because the claim was incurred after the date the Wellness Activity was completed.

The amount of the reimbursement will depend upon how much money is credited to your notional Wellness Account. You will be reimbursed in full for your 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 credited in your account. If you are covered under both the Health Care Reimbursement Account (HCRA) and the Wellness Account, claims will first be paid from your HCRA.

Your account balance will automatically roll forward to the next year as long as you remain eligible or until you have used-up your account funds. If you terminate your PG&E-sponsored medical plan coverage for active non-union represented employees (for example, you transfer to a union-represented position, leave the Company, drop coverage or retire), you will forfeit the balance in the notional account. To continue in a PG&E-sponsored medical plan after you terminate employment, see COBRA COVERAGE in the COBRA AND CONVERSION TO AN INDIVIDUAL MEDICAL POLICY section of the Handbook.

Wellness Account claims are processed daily. You can easily access your account balance, enter a new claim and view the reimbursement schedule by logging in to your account. Your account balance is available at any time over the phone by calling ConnectYourCare at 1-888-439-5121

Eligible Expenses

You can use your Wellness Account to pay for most eligible tax-deductible health care expenses for you and your eligible dependents[1] — even if they are not enrolled in a Company-sponsored health care plan. 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. To be eligible, the service must be received during the period in which you and your spouse or registered domestic partner are enrolled in a PG&E-sponsored medical plan, and after completion of a Wellness Activity. If you are enrolled in a PG&E-sponsored medical plan and did not complete a Wellness Activity until mid-year, for example, expenses incurred before you completed a Wellness Activity are not eligible for reimbursement. Likewise, if you do not continue enrollment in a PG&E-sponsored medical plan during an unpaid leave of absence, for example, expenses for health care services received during the period of the leave when you were not enrolled in a PG&E-sponsored medical plan are not eligible for reimbursement.

Eligible health care expenses are subject to rules set by the IRS. Eligible expenses include, but are not limited to:

Most health care expenses not covered or not paid in full by a health care plan, including any deductibles, copayments, or out-of-pocket expenses for prescription drugs and out-of-network services

- Ambulance services
- Certain over-the-counter drugs (see OVER-THE-COUNTER DRUGS in this section of the booklet)
- Chiropractic care by a licensed chiropractor
- Contact lenses
- Crutches
- Hearing aids
- Medical, dental or vision expenses over the Plan maximums or outside the scope of the Plan
- Routine physical exams and vaccinations
- Sterilizations
- Massage with a letter from a physician
  (The letter must cite the specific medical condition being treated and indicate that massage will treat or alleviate it.)
- Laser eye surgery
- Athletic club dues with a letter from a physician
  (The letter must cite the specific medical condition being treated and indicate that athletic activities will treat or alleviate it.)

[1] Your eligible dependents are individuals who qualify as dependents under Internal Revenue Code Section 152, as modified by Code Section 105.

Ineligible Expenses

Ineligible expenses include, but are not limited to:

- Health care premiums
- Athletic club dues (see ELIGIBLE EXPENSES in this section of the booklet for when charges are allowed)
- Marriage counseling
- Maternity clothes
- Weight-loss programs taken for your general health
- Certain over-the-counter drugs (see OVER-THE-COUNTER DRUGS in this section of the booklet)
- Cosmetic surgery
- Cosmetic dental surgery
- Drugs to stimulate hair growth (e.g., Rogaine)
- Any expense already paid by another one of your health care plans
- Many other expenses not considered a tax-deductible health care expense by the IRS

Over-the-Counter Drugs

Many non-prescription, over-the-counter (OTC) drugs, medicines and medical care items are considered eligible for reimbursement under Wellness Account. OTC drugs and items generally fall into one of the following three categories:

1. Those eligible for reimbursement because they are used primarily for medical care.
2. Those ineligible for reimbursement because they are merely beneficial for general health.
3. Those ineligible for reimbursement that become eligible for reimbursement with a letter from the attending physician. The letter must cite the specific medical condition being treated and indicate that the OTC drug or medication will treat or alleviate it.

Eligible for Reimbursement

The following is a sample list of over the counter (OTC) drugs and medical care items that are eligible for reimbursement under the Wellness Account. The list does not include all available OTC drugs and medical care items. Please note that the items eligible for reimbursement may change. To determine whether certain expenses, including OTC drugs and medications, are eligible for reimbursement under your Wellness Account, please contact ConnectYourCare.

Please note: Items marked with PS require a physician's statement to establish eligibility for reimbursement.

Wellness Accounts

ELIGIBLE FOR REIMBURSEMENT	
PRODUCT TYPE	**EXAMPLES INCLUDE, BUT ARE *NOT* LIMITED TO:**
Acne Medications [PS] pill, liquid, cream, ointment, medicated soaps and cleansing pads	Clean & Clear, Clearasil, Loma Lux Acne, Nature's Cure
Allergy Medicines pill, liquid, nasal spray (see also "Eye Drops")	Benadryl, Chlor-Trimeton, Claritin, Drixoral, NasalCrom, Tavist Allergy
Antacids (anti-gas, lactose intolerance) liquids, pills, tablets	Alka-Seltzer, Beano, Gas-X, Lactaid, Maalox, Mylanta, Pepcid, Pepto-Bismol, Phazyme, Rolaids, Tums
Antibiotic creams/ointments	Bacitracin, Neosporin, Polysporin
Antidiarrheal liquids, pills	Imodium, Kaopectate, Pepto-Bismol
Anti-Fungal Creams & Powders	Aftate, Cruex, Lamisil, Lotrimin, Micatin, Tinactin
Anti-Itch Creams (allergy and poison ivy)	Benadryl, Cortaid, Ivarest, Lanacort
Baby Care Products	Diaper rash cream/ointment, rehydration liquids (Pedialyte, PediaSure), teething gel
Braces and supports	Braces and supports for neck, wrist, ankle, elbow, knee, etc.; support stockings
Canker and Cold Sore Remedies	Abreva, Anbesol, Cankaid, Carmex Kank-A
Cold Medicines	Cough & sore throat lozenges/drops, cough syrup, decongestants, homeopathic cold medicines, nasal sprays, TheraFlu, Tylenol Cold, vapor rubs
Contraceptives/Family Planning	Condoms, contraceptive creams, pregnancy tests, ovulation predictor kits
Diabetic Supplies/Equipment	Alcohol swabs; blood glucose control solutions, monitors, strips and products; lancets and lancet devices, urine testing products
Ear Drops (ear wax removal [PS])	Auro Ear Drops, Debrox Ear Drops, Murine Ear Drops
Eye Care Products	Saline and cleaning solutions, eyeglasses, contact lenses
Eye Drops/Eye Wash Products	Eye wash products to clean out eye or remove foreign objects, Murine, Visine
Feminine Yeast Infection Medicine	Gyne-Lotrimin, Monistat
First Aid	Bandages, dressings, first aid kits, peroxide, rubbing alcohol
Hemorrhoidal Preparations	Preparation H, Tucks
Home Diagnostic Tests or Kits	Cholesterol, colorectal, drug, HIV, ovulation predictor, pregnancy and urine tests; thermometers (ear or standard)

Wellness Accounts

ELIGIBLE FOR REIMBURSEMENT	
PRODUCT TYPE	**EXAMPLES INCLUDE, BUT ARE *NOT* LIMITED TO:**
Hot/Cold Packs	ThermaCare
Laxatives (fiber therapy PS)	Citrucel, Dulcolax, Ex-Lax, FiberCon, Fleet, Metamucil, Milk of Magnesia, Peri-Colace
Lice Treatments	LiceFree, Nix, Pronto, Rid
Motion Sickness Medicine	Bonine, Dramamine, motion sickness wristbands
Pain Relievers	Acetaminophen, Advil, Aleve, Anbesol, Aspercreme, aspirin, aspirin, Ben-Gay, homeopathic pain relievers, ibuprofen, Icy Hot, Midol, Mineral Ice, Motrin, naproxen sodium, pain relieving gels, Tylenol
Pain Relievers – Urinary Tract	Cystex, Uristat
Smoking Cessation Medicine - patches and gum	Nicoderm, Nicorette, Nicotrol, Novartis
Wart or Corn Removers - liquid or pads	Compound W, Curad, Dr. Scholl's Corn Remover, Wart-Off

Not Eligible for Reimbursement

The following is a sample list of over the counter (OTC) drugs and medical care items that are not eligible for reimbursement under the Wellness Account. The list does not include all the non-eligible OTC drugs and medical care items. Please note that items which are not reimbursable may change. To determine whether expenses, including OTC drugs and medications, are eligible for reimbursement under your Wellness Account, please contact ConnectYourCare.

NOT ELIGIBLE FOR REIMBURSEMENT	
PRODUCT TYPE	**EXAMPLES INCLUDE, BUT ARE *NOT* LIMITED TO:**
Bath Products, Cleansers, Soap	Aveeno, Dial, Dove, Softsoap
Creams, Lip Balm, Lipstick, Lotions, Moisturizers	Basis, Biore, Eucerin, L'Oreal, Neutrogena, Nivea, Noxzema, Oil of Olay, PHisoderm
Dental – Miscellaneous	Breath fresheners; dental floss, adhesives, cleansers, gel, gum, rinses; oral cleaning systems (Water Pik); tongue scrapers; whitening products/systems; toothbrushes; toothpaste
Deodorants/Anti-Perspirants	Ban, Brut, Dry Idea, Speed Stick
Feminine Hygiene	Always, douches, feminine lubricants and pads, tampons
Foot Care Products	Arch and insole supports PS, Dr. Scholl's callus removers, Odor-Eaters, pedicure products, shoes, toenail clippers
Hair Care Products	Conditioner and shampoo (including those used for dandruff), hairspray, styling aids
Hair Removal Products	Hair-removal creams, razors, wax
Medicine Dispensers	Medicine droppers, pill organizers
Powders	Non-fungus fighting foot powders
Shaving and Grooming Products	Aftershave, razors, shaving cream
Snoring Aids PS	Nose drops and strips
Stimulants (to stay awake)	No Doz, Vivarin
Sunscreen, Sunless Tanning, After Sun Products PS	Coppertone, Hawaiian Tropic

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. Contact ConnectYourCare if you have questions about how claims for ongoing treatment programs will be reimbursed.

Wellness Account Claims and Appeals

Claims

If a Wellness Account claim you submit is denied in part or whole, ConnectYourCare, as the third-party 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 of the Claims Administrators receipt of your claim.

Send your appeal to:

ConnectYourCare
Claims Appeals Department
307 International Circle, Suite 200
Hunt Valley, MD 21030

If the Claims Administrator needs 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.

Appeals

If you believe this initial determination denies you a Wellness Account benefit to which you may be entitled, you may appeal to the Plan Administrator.

Send your appeal to:

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

This appeal must be made in writing within 180 days of the initial determination of the amount that has been paid to you 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 FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION form. You can access a copy online from the **Plans, Policies & Forms > Human Resources Forms** section of the PG&E HR intranet site or by calling the HR Service Center at 415-973-HELP (415-973-4357) or toll-free at 1-800-788-2363.

The Benefits Department will generally make a decision within 30 days after receiving the appeal and mail a copy of the decision to you promptly. The decision will give specific reasons and references to the Wellness Account Plan provisions which support the Benefits Department's decision.

If you are not satisfied by the findings of the Benefits Department, you may formally appeal in writing to the Employee Benefit Appeals Committee. You have 90 days from the date on which you receive a decision from the Benefits Department to formally submit your appeal. You should include all relevant information in your appeal.

Send your appeal to:

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

You shall receive EBAC's decision within 30 days of EBAC's receipt of the appeal unless special circumstances require an extension for processing the appeal. If special circumstances exist, EBAC may take up to an additional 30 days provided you are notified of the extension in writing within the initial 30 day period.

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

- the specific reason(s) for the denial of the claim;
- 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.

Questions About Claims for Reimbursement

You should refer any questions about your claims for reimbursement to Claims Administrator at the following address and/or call 1-888-439-5121.

ConnectYourCare
Claims/Customer Service
307 International Circle, Suite 200
Hunt Valley, MD 21030

More About the Wellness Account

Wellness Account Limitations

The Wellness Account is governed by IRS regulations. You should keep in mind these regulations and limitations:

- If you have a Wellness Account, Health Care Reimbursement Account and/or a Dependent Care Reimbursement Account, you cannot transfer money between any of the accounts.
- All of the money in your account must be used to pay for services received after completion of a wellness activity during the period for which it was allocated. Any unused money left in a Wellness Account after all expenses for the Plan Year have been submitted will be carried forward into the next year.

Deadline for Claim Reimbursements

Claims can be submitted for reimbursement from the Wellness Account for eligible expenses for services received during the months you or your spouse or registered domestic partner were covered under a PG&E-sponsored medical plan. 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.**

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 Wellness Account because eligibility for the Wellness Account is tied to your enrollment in a PG&E-sponsored medical plan.

You can submit claims for reimbursement from the Wellness Account for eligible expenses for services received during the months you were an active Management and Administrative & Technical employee and employed by the Company. 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.

For more information, please contact the HR Service Center at 415-973-HELP (415-973-4357) or toll-free at 1-800-788-2363 for more information.

If You Are on Long-Term Disability

If you are on long-term disability (LTD), you are not eligible to participate in the Wellness Account. If you become disabled and go on LTD, your eligibility will stop at the end of the month in which you go on LTD.

You can submit claims for reimbursement from the Wellness Account for eligible expenses for services received during the months you were an active Management and Administrative & Technical employee and employed by the Company. 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.

For more information, please contact the HR Service Center at 415-973-HELP (415-973-4357) or toll-free at 1-800-788-2363 for more information.

If You Transfer to a Union-Represented Employee Position, Leave the Company or Retire

If you transfer to a union-represented employee position, retire or leave the Company, you will no longer be eligible for the Wellness Account and will forfeit any balances in the account. If you leave the Company, you can continue your participation in the Wellness Account when you enroll in a PG&E-sponsored medical plan through COBRA (see the COBRA AND CONVERSION TO AN INDIVIDUAL MEDICAL POLICY of the Handbook). However, if participation is not continued through COBRA, your eligibility will stop at the end of the month in which you transfer to a union-represented employee position, leave the Company or the end of the month prior to your retirement.

You can submit claims for reimbursement from the Wellness Account for eligible expenses for services received during the months you were an active Management and Administrative & Technical employee and employed by the Company. 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.

For more information, please contact the HR Service Center at 415-973-HELP (415-973-4357) or toll-free at 1-800-788-2363 for more information.

If You are Re-hired by the Company or Transfer from a Union-Represented Employee Position

Any money remaining in the account after March 31 of the following year after your transfer to a union-represented employee position, leave the Company or retire will be forfeited. If you are later re-hired by the Company or transfer from a union-represented employee position to a Management and Administrative & Technical employee position, there will be no reinstatement of any forfeited Wellness Account balances.

The Wellness Account and COBRA for Spouses and Registered Domestic Partners

In the event of a divorce, dissolution or legal separation, your former opposite-sex spouse can continue participation in the Wellness Account when he or she enrolls in a PG&E-sponsored medical plan through COBRA. Your former same-sex spouse or registered domestic partner can continue participation through the continuation coverage that PG&E extends to same-sex spouses and registered domestic partners. (See the COBRA AND CONVERSION TO AN INDIVIDUAL MEDICAL POLICY of the Handbook). Both forms of continuation coverage are referred to in this section for ease of reference as "COBRA.")

If COBRA is elected, a separate Wellness Account will be established for your former spouse or registered domestic partner by ConnectYourCare 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

COBRA is not elected, your former spouse or registered domestic partner's eligibility for the Wellness Account will stop at the end of the month in which the qualifying event occurred.

Claims can be submitted for reimbursement from the Wellness Account for eligible expenses for services received during the months the former spouse or registered domestic partner was covered under a PG&E-sponsored medical plan. 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.

For more information, please contact the HR Service Center at 415-973-HELP (415-973-4357) or toll-free at 1-800-788-2363 for more information.

ERISA Information

Funding

The following language replaces the first paragraph under ADMINISTRATIVE INFORMATION ABOUT THE PLAN – FUNDING in Subsection B-VIII – ERISA INFORMATION of Section B – HEALTH CARE BENEFITS of the Handbook.

The Comprehensive Access Plan, the Network Access Plan, the Basic Plan, the Vision Plan, the Dental Plans, the Prescription Drug Plan, the Mental Health, Alcohol and Drug Care Program, and the Wellness 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.

Plan Directory

The following language adds information to the PLAN DIRECTORY in Subsection B-VIII – ERISA INFORMATION of Section B – HEALTH CARE BENEFITS of the Handbook.

PLAN NAME	PLAN TYPE	TRUSTEE, INSURANCE ISSUER AND/OR THIRD PARTY ADMINISTRATOR
WELLNESS ACCOUNT	health reimbursement arrangement medical plan	Third Party Administrator: ConnectYourCare 307 International Circle, Suite 200 Hunt Valley, MD 21030

Reimbursement Accounts

Reimbursement Accounts offer you a way to save on taxes when you pay for certain health care and dependent care expenses.

Summary of Material Modifications

This Reimbursement Accounts section of the booklet constitutes a Summary of Material Modifications to the Pacific Gas and Electric Company Health Care Plan for Active Employees (Plan), effective January 1, 2009.

In addition to being a Summary of Material Modifications, this Reimbursement Accounts section of the booklet completely replaces Section C of the Summary of Benefits Handbook for Management and Administrative & Technical Employees ("Handbook"). Unless otherwise noted, when you are referred to information in a different topic or section, the reference is to the Handbook, not this booklet.

Pacific Gas and Electric Company has the right to amend or terminate the Plan at any time and for any reason. Generally, an amendment to or termination of the plan will apply prospectively and will affect your rights and obligations under the Plan prospectively.

Summary of Benefits

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 "reimbursement accounts" each year.

You may elect to set up two different kinds of reimbursement accounts—also known as Flexible Spending Accounts (FSAs)—each year; one for health care expenses (the Health Care Reimbursement Account) and one for dependent care expenses (the Dependent Care Reimbursement Account). You put money into these accounts by contributing before-tax salary dollars from your 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.

If you are a Management or Administrative & Technical employee, you are eligible to enroll in the reimbursement accounts 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 MID-YEAR RE-ENROLLMENT and CHANGE-IN-STATUS EVENTS under ENROLLMENT in the FLEX PLAN section of the Handbook). You set up your reimbursement account(s) by designating an **annual** contribution amount when you enroll.

ConnectYourCare (Claims Administrator) is the third-party administrator for both the health care and dependent care accounts. If you have any questions about the Plan, IRS rules, or your claims, you may contact ConnectYourCare at 1-888-439-5121 or *www.connectyourcare.com*. Representatives are available 24 hours a day, seven days a week.

You are not eligible for reimbursement account benefits if you are an intern, contract or agency worker, hiring hall employee, employee receiving long-term disability benefits, or retired employee.

The Company[1] 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 Reimbursement Accounts are affected.

How the Reimbursement Accounts Work

Setting Up Your Reimbursement 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 MID-YEAR ENROLLMENT CHANGES and CHANGE-IN-STATUS EVENTS under ENROLLMENT in the FLEX PLAN section of the Handbook).

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 Reimbursement Account (HCRA):
  You can allocate between $50 and $5,000 a year, per individual or married couple filing a joint tax return (employees with an opposite-sex spouse filing separate tax returns may each contribute up to $2,500).
- Dependent Care Reimbursement Account (DCRA):
  You can allocate between $50 and $5,000 a year, per individual or married couple filing a joint tax return (employees with an opposite-sex 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 DCRA, if you are filing jointly. If your spouse is a full-time student or disabled, there are special limits.

The contribution rules for married individuals **do not** apply to an employee with a same-sex spouse. See MORE ABOUT REIMBURSEMENT ACCOUNTS in this section of the booklet for additional information.

For more information, contact ConnectYourCare at 1-888-439-5121 or the HR Service Center at 415-973-HELP (415-973-4357) or toll-free at 1-800-788-2363.

[1] Throughout this section, unless otherwise stated, reference to the "Company" or "PG&E" means Pacific Gas and Electric Company. The plans and benefits described in this handbook are also applicable to employees of PG&E Corporation and its designated subsidiaries, 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.

Putting Money Into Your Reimbursement Accounts

You may contribute to the reimbursement accounts by making deposits to your reimbursement accounts through payroll deductions from your before-tax pay.

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. You can use ConnectYourCare's FSA savings calculator at *www.connectyourcare.com/eecalculators* to estimate your potential tax savings.

Your deposits go directly into your accounts in equal portions each month. For Management employees, an equal amount will be deducted from each of your monthly paychecks before taxes. For Administrative & Technical 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 (see IF YOU TAKE A LEAVE OF ABSENCE WITHOUT PAY under MORE ABOUT REIMBURSEMENT ACCOUNTS in this section of the booklet).

Any money left in your account(s) 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. However, there is a three-month "run-out" period that ends March 31 of the following Plan year, during which you can submit claims for eligible services rendered in the prior year.

Reimbursement of Eligible Health Care Expenses

You use the money in your reimbursement accounts 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 HCRA.

The first step you should take when your membership in HCRA becomes effective is to log in to your FSA Account. (This is the same log-in process you use for accessing your DCRA as well.)

Go to *www.connectyourcare.com*. Select the log-in link from the upper right hand corner. If you are a new participant, choose New User Registration to select 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 balance is available at any time online, or over the phone at 1-888-439-5121.

If you are covered under both the HCRA and the Wellness Account, you will have a combined healthcare payment card. The card is programmed to deduct money first from your HCRA, since the health care reimbursement account is a "use it or lose it" program, while funds in your Wellness Account can be used in future years.

There are two ways to pay for eligible health care expenses:

Approach One: Use Your Healthcare Payment Card.

1. ConnectYourCare will automatically send you a healthcare payment card that you can use to pay for eligible expenses at a qualified merchant.

   Your healthcare payment card works in a fashion similar to a debit card. You can use it to pay copayments at the doctor's office, coinsurance for your prescription drugs, procedures allowed by the IRS but not covered by insurance and other similar transactions. The card has a swipe feature as well as a dedicated card number

   The card can be used to access the total value of your HCRA. However, it can only be used for merchants that have been deemed as healthcare merchants. Examples of qualified merchants may include pharmacies, doctors' offices, vision centers, and hospitals. Your payment card will automatically be activated the first time you use it.

2. Be sure to keep your itemized receipt as documentation. Although your healthcare payment card eliminates the need to file paper claims, the IRS requires that your charges be verified. **Always keep your receipts for tax purposes, in case the IRS requests them to confirm a purchase.** If a receipt is needed, ConnectYourCare will notify you within a week from the date of your healthcare payment card swipe. If they have your e-mail information, notification will be electronic. Otherwise, it will be by mail.

3. If you use the healthcare payment card for an ineligible expense or for one that ConnectYourCare does not have proper documentation, you will be required to reimburse the account for the amount of that transaction.

4. If you need to order a replacement or additional healthcare payment card, you can log in to your online account or call ConnectYourCare at 1-888-439-5121 to request another card. Be sure to call ConnectYourCare promptly if your card is lost or stolen.

5. Details on how to use your healthcare payment card, more information about how to submit expenses and which merchants accept the payment card are available at *www.connectyourcare.com* or by calling ConnectYourCare at 1-888-439-5121.

Approach Two: Pay for the Expense and File a Claim

You can also pay for out-of-pocket expenses using your own personal credit card, cash or check, and keep your itemized receipt as documentation. Then, log in to your online account to file for reimbursement. 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. **Log in to your FSA Account**. Go to *www.connectyourcare.com*. Select the log-in link from the upper right hand corner. If you are a new participant, choose New User Registration to select 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 balance is available at any time online, or over the phone.

   To file a claim online:

   a. Log in to your online account and select Claim Center from the main menu across the top of the screen.

   b. Click on Add New Claim from the left-hand menu.

   c. Follow the four easy steps on the screen to enter information about your claim.

   d. Print your cover sheet and then send it by fax or e-mail (as a .tif or .pdf file) with your receipts to the number/e-mail address shown on the form.

   If you need help determining which of your expenses are eligible, you should contact ConnectYourCare. Eligibility for reimbursement is based on when services are actually received, regardless of when you pay for such expenses. For further details, see ELIGIBLE EXPENSES under HEALTH CARE REIMBURSEMENT ACCOUNT in this section of the booklet.

4. **Print and mail the completed claim submission form**, along with original invoices and any applicable explanation of benefits (EOBs) or health plan website claims print-outs to:

   ConnectYourCare Processing Center
   307 International Circle, Suite 200
   Hunt Valley, MD 21030

   Be sure to keep a photocopy of everything for yourself before you submit it to the ConnectYourCare processing center. Or you may fax your completed claims submission form and a copy of the original invoices to 1-866-879-0812.

5. **Processing of 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 by signing up at *www.connectyourcare.com*. If you chose automatic bank account deposits for your reimbursement accounts for a calendar year, the election will automatically roll over when you re-enroll in the Plan for a future year.

Reimbursement of Eligible Dependent Care Expenses

You use the money in your reimbursement accounts 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 DCRA.

Pay for out-of-pocket expenses using your own personal credit card, cash or check, and keep your itemized receipt as documentation. Then, log in to your online account to file for reimbursement. You must file all dependent care claims through this process.

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. **Log in to your FSA Account.** Go to *www.connectyourcare.com*. Select the log-in link from the upper right hand corner. If you are a new participant, choose New User Registration to select 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 balance is available at any time online, or over the phone at 1-888-439-5121.

   To file a claim online:

   a. Log in to your online account and select Claim Center from the main menu across the top of the screen.

   b. Click on Add New Claim from the left-hand menu.

   c. Follow the four easy steps on the screen to enter information about your claim.

   d. Print your cover sheet and then send it by fax or e-mail (as a .tif or .pdf file) with your receipts to the number/email address shown on the form.

   If you need help determining which of your expenses are eligible, you should contact ConnectYourCare. Eligibility for reimbursement is based on when services are actually received, regardless of when you pay for such expenses. See ELIGIBLE EXPENSES under DEPENDENT CARE REIMBURSEMENT ACCOUNT in this section of the booklet for further details.

3. **Print and mail the completed claim submission form,** along with original invoices to:

   ConnectYourCare Processing Center
   307 International Circle, Suite 200
   Hunt Valley, MD 21030

   Be sure to keep a photocopy of everything for yourself before you submit it to the ConnectYourCare processing center. Or you may fax your completed claims submission form and a copy of the original invoices to 1-866-879-0812.

   Receipts MUST include the following information:

   a. Name of the dependent

   b. Date the service was provided

   c. Name of the service provider

   d. Description of the service

   e. Amount/cost of the item or service provided

   Please note that credit card receipts, non-itemized cash register receipts and cancelled checks are not acceptable forms of documentation.

4. **Processing of Claim.** 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 by signing up at *www.connectyourcare.com*. If you chose automatic bank account deposits for your reimbursement account for a calendar year, the election will automatically roll over when you re-enroll in the Plan for a future calendar year.

Availability of Annual Contributions for Reimbursement

For the HCRA, 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 DCRA claims, the amount of the reimbursement will depend upon how much money is in your account. You will be reimbursed in full for your 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.

HCRA and DCRA claims are processed daily.

Health Care Reimbursement Account (HCRA)

Eligible Expenses

You can use your Health Care Reimbursement Account (HCRA) to pay for most eligible tax-deductible health care expenses for you and eligible dependents[1] — even if they are not enrolled in a Company-sponsored health care plan. 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. To be eligible, the service must be received during the period in which you have contributed to HCRA. 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). Eligible expenses include, but are not limited to:

- **Most health care expenses not covered or not paid in full by a health care plan, including any deductibles, copayments, or out-of-pocket expenses for prescription drugs and out-of-network services**
- **Ambulance services**
- **Certain over-the-counter drugs (see OVER-THE-COUNTER DRUGS in this section of the booklet)**
- **Chiropractic care by a licensed chiropractor**
- **Contact lenses**
- **Crutches**
- **Dental Implants**
- **Hearing aids**

The plan document for The Pacific Gas and Electric Company Health Care Reimbursement Account Plan contains the detailed provisions of the Plan and governs the operation of the Health Care Reimbursement Account Plan. If a conflict exists between the Plan document and any other communications or documents, the Plan document shall govern the operation of the health Care Reimbursement Account Plan.

The Employee Benefit Committee of PG&E Corporation is the Plan Administrator of the Health Care Reimbursement Account Plan and 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.

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[1] Your eligible dependents are individuals who qualify as dependents under Internal Revenue Code Section 152, as modified by Code Section 105.

- Medical, dental or vision expenses over the Plan maximums or outside the scope of the Plan
- Routine physical exams and vaccinations
- Sterilizations
- Massage with a letter from a physician
  (The letter must cite the specific medical condition being treated and indicate that massage will treat or alleviate it.)
- Laser eye surgery
- Athletic club dues with a letter from a physician
  (The letter must cite the specific medical condition being treated and indicate that athletic activities will treat or alleviate it.)

Ineligible Expenses

Ineligible expenses include, but are not limited to:

- Health care premiums
- Athletic club dues (see ELIGIBLE EXPENSES in this section of the booklet for when charges are allowed)
- Marriage counseling
- Maternity clothes
- Weight-loss programs taken for your general health
- Certain over-the-counter drugs (see OVER-THE-COUNTER DRUGS in this section of the booklet)
- Cosmetic surgery
- Cosmetic dental surgery
- Drugs to stimulate hair growth (e.g., Rogaine)
- Any expense already paid by another one of your health care plans
- Many other expenses not considered a tax-deductible health care expense by the IRS

Over-the-Counter Drugs

Many non-prescription, over-the-counter (OTC) drugs, medicines and medical care items are considered eligible for reimbursement under Health Care Reimbursement Account (HCRA). OTC drugs and items generally fall into one of the following three categories:

1. Those eligible for reimbursement because they are used primarily for medical care.
2. Those ineligible for reimbursement because they are merely beneficial for general health.
3. Those ineligible for reimbursement that become eligible for reimbursement with a letter from the attending physician. The letter must cite the specific medical condition being treated and indicate that the OTC drug or medication will treat or alleviate it.

Reimbursement Accounts
Health Care Reimbursement Account (HCRA)

Eligible for Reimbursement

The following is a sample list of over the counter (OTC) drugs and medical care items that are eligible for reimbursement under the Health Care Reimbursement Account (HCRA). The list does not include all available OTC drugs and medical care items. Please note that the items eligible for reimbursement may change. To determine whether certain expenses, including OTC drugs and medications, are eligible for reimbursement under your HCRA, please contact ConnectYourCare.

Please note: **Items marked with PS require a physician's statement to establish eligibility for reimbursement.**

ELIGIBLE FOR REIMBURSEMENT	
PRODUCT TYPE	**EXAMPLES INCLUDE, BUT ARE *NOT* LIMITED TO:**
Acne Medications PS pill, liquid, cream, ointment, medicated soaps and cleansing pads	Clean & Clear, Clearasil, Loma Lux Acne, Nature's Cure
Allergy Medicines pill, liquid, nasal spray (also see "Eye Drops")	Benadryl, Chlor-Trimeton, Claritin, Drixoral, NasalCrom, Tavist Allergy
Antacids (anti-gas, lactose intolerance) liquids, pills, tablets	Alka-Seltzer, Beano, Gas-X, Lactaid, Maalox, Mylanta, Pepcid, Pepto-Bismol, Phazyme, Rolaids, Tums
Antibiotic creams/ointments	Bacitracin, Neosporin, Polysporin
Antidiarrheal liquids, pills	Imodium, Kaopectate, Pepto-Bismol
Anti-Fungal Creams & Powders	Aftate, Cruex, Lamisil, Lotrimin, Micatin, Tinactin
Anti-Itch Creams (allergy and poison ivy)	Benadryl, Cortaid, Ivarest, Lanacort
Baby Care Products	Diaper rash cream/ointment, rehydration liquids (Pedialyte, PediaSure), teething gel
Braces and supports	Braces and supports for neck, wrist, ankle, elbow, knee, etc.; support stockings
Canker and Cold Sore Remedies	Abreva, Anbesol, Cankaid, Carmex Kank-A
Cold Medicines	Cough & sore throat lozenges/drops, cough syrup, decongestants, homeopathic cold medicines, nasal sprays, TheraFlu, Tylenol Cold, vapor rubs
Contraceptives/Family Planning	Condoms, contraceptive creams, pregnancy tests, ovulation predictor kits
Diabetic Supplies/Equipment	Alcohol swabs; blood glucose control solutions, monitors, strips and products; lancets and lancet devices, urine testing products
Ear Drops (ear wax removal PS)	Auro Ear Drops, Debrox Ear Drops, Murine Ear Drops
Eye Care Products	Saline and cleaning solutions, eyeglasses, contact lenses

Reimbursement Accounts
Health Care Reimbursement Account (HCRA)

ELIGIBLE FOR REIMBURSEMENT	
PRODUCT TYPE	**EXAMPLES INCLUDE, BUT ARE *NOT* LIMITED TO:**
Eye Drops/Eye Wash Products	Eye wash products to clean out eye or remove foreign objects, Murine, Visine
Feminine Yeast Infection Medicine	Gyne-Lotrimin, Monistat
First Aid	Bandages, dressings, first aid kits, peroxide, rubbing alcohol
Hemorrhoidal Preparations	Preparation H, Tucks
Home Diagnostic Tests or Kits	Cholesterol, colorectal, drug, HIV, ovulation predictor, pregnancy and urine tests; thermometers (ear or standard)
Hot/Cold Packs	ThermaCare
Laxatives (fiber therapy [PS])	Citrucel, Dulcolax, Ex-Lax, FiberCon, Fleet, Metamucil, Milk of Magnesia, Peri-Colace
Lice Treatments	LiceFree, Nix, Pronto, Rid
Motion Sickness Medicine	Bonine, Dramamine, motion sickness wristbands
Pain Relievers	Acetaminophen, Advil, Aleve, Anbesol, Aspercreme, aspirin, aspirin, Ben-Gay, homeopathic pain relievers, ibuprofen, Icy Hot, Midol, Mineral Ice, Motrin, naproxen sodium, pain relieving gels, Tylenol
Pain Relievers – Urinary Tract	Cystex, Uristat
Smoking Cessation Medicine - patches and gum	Nicoderm, Nicorette, Nicotrol, Novartis
Wart or Corn Removers - liquid or pads	Compound W, Curad, Dr. Scholl's Corn Remover, Wart-Off

Reimbursement Accounts
Health Care Reimbursement Account (HCRA)

Not Eligible for Reimbursement

The following is a sample list of over the counter (OTC) drugs and medical care items that are not eligible for reimbursement under the Health Care Reimbursement Account (HCRA). The list does not include all the non-eligible OTC drugs and medical care items. Please note that items which are not reimbursable may change. To determine whether expenses, including OTC drugs and medications, are eligible for reimbursement under your HCRA, please contact ConnectYourCare.

NOT ELIGIBLE FOR REIMBURSEMENT	
PRODUCT TYPE	**EXAMPLES INCLUDE, BUT ARE *NOT* LIMITED TO:**
Bath Products, Cleansers, Soap	Aveeno, Dial, Dove, Softsoap
Creams, Lip Balm, Lipstick, Lotions, Moisturizers	Basis, Biore, Eucerin, L'Oreal, Neutrogena, Nivea, Noxzema, Oil of Olay, PHisoderm
Dental – Miscellaneous	Breath fresheners; dental floss, adhesives, cleansers, gel, gum, rinses; oral cleaning systems (Water Pik); tongue scrapers; whitening products/systems; toothbrushes; toothpaste
Deodorants/Anti-Perspirants	Ban, Brut, Dry Idea, Speed Stick
Feminine Hygiene	Always, douches, feminine lubricants and pads, tampons
Foot Care Products	Arch and insole supports [PS], Dr. Scholl's callus removers, Odor-Eaters, pedicure products, shoes, toenail clippers
Hair Care Products	Conditioner and shampoo (including those used for dandruff), hairspray, styling aids
Hair Removal Products	Hair-removal creams, razors, wax
Medicine Dispensers	Medicine droppers, pill organizers
Powders	Non-fungus fighting foot powders
Shaving and Grooming Products	Aftershave, razors, shaving cream
Snoring Aids [PS]	Nose drops and strips
Stimulants (to stay awake)	No Doz, Vivarin
Sunscreen, Sunless Tanning, After Sun Products [PS]	Coppertone, Hawaiian Tropic

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. Contact ConnectYourCare if you have questions about how claims for ongoing treatment programs will be reimbursed.

Reimbursement Accounts
Health Care Reimbursement Account (HCRA)

Changing Your Annual Contribution Amount

Normally, you may not change the amount you contribute to your Health Care Reimbursement Account or stop payroll deductions mid-year. However, you may be able to increase or decrease your current HCRA annual contribution goal during the year if you have certain eligible change-in-status events. The increase or decrease must be consistent with the change in status. (See MID-YEAR ENROLLMENT CHANGES and CHANGE-IN-STATUS EVENTS under ENROLLMENT in the FLEX PLAN section of the Handbook.)

Health Care Reimbursement Account Claims and Appeals

Claims

If a Health Care Reimbursement claim you submit is denied in part or whole, ConnectYourCare, as the third-party 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 when the Claims Administrator received your claim.

Send your appeal to:

ConnectYourCare
Claims Appeals Department
307 International Circle, Suite 200
Hunt Valley, MD 21030

If the Claims Administrator needs 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.

Appeals

If you believe the initial determination denies you a Health Care Reimbursement Account benefit to which you may be entitled, you may appeal to the Plan Administrator.

Send your appeal to:

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

This appeal must be made in writing within 180 days of the initial determination of the amount that has been paid to you and must contain the following information:

- The reason(s) for making the appeal;
- The facts supporting the appeal;
- The amount claimed; and

Reimbursement Accounts
Health Care Reimbursement Account (HCRA)

- The name and address of the person filing the appeal (claimant).

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 **Plans, Policies & Forms > Human Resources Forms** section of the PG&E HR intranet site or by calling the HR Service Center at 415-973-HELP (415-973-4357) or toll-free at 1-800-788-2363.

The Benefits Department will generally make a decision within 30 days after receiving the appeal and mail a copy of the decision to you promptly. The decision will give specific reasons and references to the Health Care Reimbursement Account Plan provisions which support the Benefits Department's decision.

If you are not satisfied by the findings of the Benefits Department, you may formally appeal in writing to the Employee Benefit Appeals Committee. You have 90 days from the date on which you receive a decision from the Benefits Department to formally submit your appeal. You should include all relevant information in your appeal.

Send your appeal to:

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

You shall receive EBAC's decision within 30 days of EBAC's receipt of the appeal unless special circumstances require an extension for processing the appeal. If special circumstances exist, EBAC may take up to an additional 30 days provided you are notified of the extension in writing within the initial 30 day period.

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

- the specific reason(s) for the denial of the claim;
- 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 Reimbursement Account (DCRA)

Whose Expenses May Be Reimbursed?

The definition of a DCRA 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 Reimbursement Account.

The following table lays out the requirements for the three types of DCRA Dependents. To be considered a Dependent for DCRA 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 DCRA Dependent, and you may not be reimbursed for his or her expenses.

The three categories of DCRA Dependents are:

- **Column A: your children and other relatives. Most people use the DCRA for daycare 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 DCRA 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 DCRA Dependent. See Column C for these requirements.**

The plan document for The Pacific Gas and Electric Company Dependent Care Reimbursement Account Plan contains the detailed provisions of the Plan and governs the operation of the Plan. If a conflict exists between the Plan document and any other communications or documents, the Plan document shall govern the operation of the Dependent Care Reimbursement Account Plan.

The Employee Benefit Committee of PG&E Corporation is the Plan Administrator of the Dependent Care Reimbursement Account Plan and 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.

Reimbursement Accounts
Dependent Care Reimbursement Account (DCRA)

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 **IF THE PERSON SATISFIES EVERY REQUIREMENT IN THIS COLUMN, HE OR SHE IS A DCRA DEPENDENT.** **IF THE PERSON FAILS ANY ONE OR MORE OF THESE REQUIREMENTS, TRY COLUMN B OR C.**	B **IF THE PERSON SATISFIES EVERY REQUIREMENT IN THIS COLUMN, HE OR SHE IS A DCRA DEPENDENT.** **IF THE PERSON FAILS ANY ONE OR MORE OF THESE REQUIREMENTS, TRY COLUMN A OR C.**	C **IF THE PERSON SATISFIES EVERY REQUIREMENT IN THIS COLUMN, HE OR SHE IS A DCRA DEPENDENT.** **IF THE PERSON FAILS 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

Reimbursement Accounts
Dependent Care Reimbursement Account (DCRA)

REQUIREMENTS	A	B	C
	IF THE PERSON SATISFIES EVERY REQUIREMENT IN THIS COLUMN, HE OR SHE IS A DCRA DEPENDENT. **IF THE PERSON FAILS 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 DCRA DEPENDENT.** **IF THE PERSON FAILS 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 DCRA DEPENDENT.** **IF THE PERSON FAILS ANY ONE OR MORE OF THESE REQUIREMENTS, TRY COLUMN A OR B.**
AGE AND DISABILITY REQUIREMENT	Dependent must be less than 13 years old OR Dependent must be physically or mentally incapable of self-care ("disabled") and under age • 19 or • 24 if a full-time student	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 DCRA 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 DCRA 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 DCRA 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 DCRA. 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 MAY BE REIMBURSED FROM A DCRA?
- 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.

Changing Your Annual Contribution Amount

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 CHANGE-IN-STATUS EVENTS and OTHER CHANGES INVOLVING A DOMESTIC PARTNERSHIP under ENROLLMENT in the FLEX PLAN section of the Handbook. You may also make a corresponding change to your DCRA 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 DCRA 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 Dependent Care Reimbursement Account would be allowed. Or 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 DCRA 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).

Tax Credits

The Dependent Care Reimbursement Account 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 DCRA 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.

Reimbursement Accounts
Dependent Care Reimbursement Account (DCRA)

- 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 DCRA and the Federal Dependent Care Income Tax Credit, but not for the same expenses. In other words, if you open a DCRA, 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 DCRA to pay for expenses not used in figuring your tax credit.
- Every dollar that you contribute to the DCRA 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.

As tax savings of the DCRA 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).

Dependent Care Reimbursement Account Claims and Appeals

Claims

If a Dependent Care Reimbursement claim you submit is denied in part or whole, ConnectYourCare, as the third-party 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 appeal to:

ConnectYourCare
Claims Appeals Department
307 International Circle, Suite 200
Hunt Valley, MD 21030

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 appeal to:

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

Reimbursement Accounts
Dependent Care Reimbursement Account (DCRA)

This appeal must be made in writing within 90 days of the initial determination 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).

The Benefits Department will generally make a decision within 60 days after receiving the appeal and must mail a copy of the decision to you promptly. The decision will give specific reasons and references to the Dependent Care Reimbursement Account Plan provisions which support the Benefit Department's decision.

If you are not satisfied by the findings of the Benefits Department, you may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). Appeals to EBAC must be received within 90 days of your receipt of a denial by the Benefits Department. You must submit a new appeal in writing stating the reason(s) for your appeal and enclosing all relevant documentation and information that support your appeal.

Send your appeal to:

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

You shall receive EBAC's decision within 30 days of EBAC's receipt of the appeal unless special circumstances require an extension for processing the appeal. If special circumstances exist, EBAC may take up to an additional 30 days provided you are notified of the extension in writing within the initial 30 day period.

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

- the specific reason(s) for the denial of the claim;
- 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.

More About Reimbursement Accounts

Reimbursement Account Limitations

Reimbursement accounts 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, termination of a domestic partnership if the domestic partner was a tax dependent, death of a spouse/tax dependent registered domestic partner or child, birth or adoption of a child, a gain or loss of your spouse's/tax dependent registered domestic partner's employment, a change in employment status by you or your spouse/tax dependent registered domestic partner, a change of caregivers or a change in the cost for the services of a caregiver who is not a relative, or certain other losses of coverage.

  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 (60 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 Reimbursement Account goal. See MID-YEAR ENROLLMENT CHANGES and CHANGE-IN-STATUS EVENTS under ENROLLMENT in the FLEX PLAN section of the Handbook.

- If you have both a Health Care Reimbursement Account and a Dependent Care Reimbursement Account, 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. Any money left in a Reimbursement Account after all expenses for the Plan Year have been submitted is, under tax law, forfeited. You cannot carry 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 Reimbursement Account contributions.

Deadline for Claim Reimbursements

Reimbursements for eligible expenses incurred through December 31 can be submitted to the processing center up until March 31 of the following year, provided funds have not already been exhausted. **In accordance with IRS restrictions, any money remaining in the account after March 31 will be forfeited.**

If You Take a Leave of Absence Without Pay

Health Care Reimbursement Account (HCRA)

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 HCRA. Whether you elect to continue or cancel your contributions, you must complete a Health Care Reimbursement Account (HCRA) Election While on Unpaid Leave of Absence form and return it to the Benefits Service Center within 15 days of receipt.

During the First Calendar Year of Your Leave

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 Reimbursement Account 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 Health Care Reimbursement Account, 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 X $100 = $300, plus 6 X $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 a Health Care Reimbursement Account until the next Open Enrollment period, unless you have an eligible change in status.

During the Second Calendar Year of Your Leave

If your 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 HCRA contributions while on leave during the new calendar year.

- If you elected to contribute to a HCRA during Open Enrollment, you will be sent an election form on which you must indicate whether or not you wish to contribute to your HCRA 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 HCRA 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 Health Care Reimbursement Account 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 a HCRA 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 Reimbursement Account (DCRA)

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 Reimbursement Account (DCRA) 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 reimbursement 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 HCRA or DCRA. If you are on Workers' Compensation, during the annual Open Enrollment period you may not elect to contribute to a HCRA unless you are also on an FMLA leave (see LEAVES OF ABSENCE in the TIME OFF section of the Handbook for a description of FMLA leaves) and you may not contribute to DCRA. To continue your HCRA contributions while on

Workers' Compensation, you must contact the HR Service Center at 415-973-HELP (415-973-4357) or toll-free at 1-800-788-2363.

If You Retire or Leave the Company

Monthly contributions to the DCRA will stop at the earlier of the end of the month in which you leave the Company, die or the end of the month prior to your retirement.

You may continue your HCRA contributions until the end of the current year on an **after-tax** basis if participation is continued through COBRA (see the COBRA AND CONVERSION TO AN INDIVIDUAL MEDICAL POLICY section of the Handbook). 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 HCRA 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 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.

For more information, please contact the HR Service Center at 415-973-HELP (415-973-4357) or toll-free at 1-800-788-2363.

Questions About Claims for Reimbursement

You should refer any questions about your claims for reimbursement to ConnectYourCare, the Claims Administrator, at the following address and/or call 1-888-439-5121.

ConnectYourCare
Claims/Customer Service
307 International Circle, Suite 200
Hunt Valley, MD 21030

ERISA Information

Summary

As a participant in the Health Care Reimbursement Account described in this booklet, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). The Pacific Gas and Electric Company Dependent Care Reimbursement Account is not a welfare plan under ERISA and therefore the information included under this ERISA Information topic does not apply to the Dependent Care Reimbursement Account.

Your Rights 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 unit 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 description. The administrator may make a reasonable charge 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 reimbursement account coverage for yourself, spouse/domestic partner 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 on the rules governing your COBRA continuation coverage rights.

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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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 the above 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, if it finds your claim is frivolous.

Assistance with Your Questions

If you have 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.

Administrative Information About the Plan

NAME AND ADDRESS OF EMPLOYER	The Pacific Gas and Electric Company Health Care Reimbursement 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

Reimbursement Accounts
ERISA Information

PARTICIPATING EMPLOYERS	The 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 Reimbursement Account Plan
PLAN NUMBER:	526 (Health Care Reimbursement Account Plan only)
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 Reimbursement Account Plan and the Dependent Care Reimbursement Account Plan: ConnectYourCare Claims/Customer Service 307 International Circle, Suite 200 Hunt Valley, MD 21030
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.

Reimbursement Accounts
ERISA 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 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. Your Pacific Gas and Electric Company Health Care Reimbursement Account Plan is a "welfare" plan.
FUNDING	The Pacific Gas and Electric Company Health Care Reimbursement 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 Pacific Gas and Electric Company Dependent Care Reimbursement 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.

Plan Amendment and Termination

The Company, acting through its authorized representatives, reserves the right to amend or terminate the Plan at any time and for any reason, or suspend contributions to the Plan, in whole or in part, at any time.

Any change or termination to either the Pacific Gas and Electric Company Health Care Reimbursement Account Plan or the Pacific Gas and Electric Dependent Care Reimbursement Account Plan 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 the Plans for any reason without replacing it, you will be given notice. The Plan may 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 Plan.

COBRA Premium Reduction Provisions

Summary of Material Modification

This Summary of the COBRA Premium Reduction Provisions section of the booklet constitutes a Summary of Material Modifications (SMM) to the Pacific Gas and Electric Company Health Care Plan for Active Employees (the Plan), effective March 2009.

In addition to being a Summary of Material Modifications, this Summary of the COBRA Premium Reduction Provisions under ARRA section of the booklet supplements the information contained in Section D – COBRA AND CONVERSION TO AN INDIVIDUAL MEDICAL POLICY of the Summary of Benefits Handbook for Management and Administrative & Technical Employees ("Handbook"). Unless otherwise noted, when reference is made to a different topic or section, the reference is to the Handbook, not this booklet.

Pacific Gas and Electric Company has the right to amend or terminate the Plan at any time and for any reason. Generally, an amendment to or termination of the Plan will apply prospectively and will affect your rights and obligations under the Plan prospectively.

Summary of Benefits

This section contains important information about your right to continue your health care coverage in the Pacific Gas and Electric Company Health Care Plan for Active Employees (the Plan). Please read the information contained in this section very carefully.

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009, and can last up to nine months.

Eligibility

To be considered an "Assistance Eligible Individual" and get reduced premiums you:

- MUST be eligible for COBRA coverage at any time during the period from September 1, 2008, through December 31, 2009, and elect the coverage;
- MUST have a COBRA coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008, through December 31, 2009;
- MUST NOT be eligible for Medicare; AND

- **MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a spouse's employer or the Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents.***

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008, through February 16, 2009, and were offered, but did not elect, COBRA coverage OR who elected COBRA coverage and subsequently discontinued it may have the right to an additional 60-day election period.

♦ IMPORTANT ♦

- **If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare, you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.**
- **Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.**
- **The amount of the premium reduction is recaptured for certain high-income individuals. If the amount you earn for the year is more than $125,000 (or $250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at *www.irs.gov*.**

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 1-800-977-7994.

To notify Ceridian of your ineligibility to continue paying reduced premiums, mail the Notification of Ineligibility of Premium Reduction form to: Ceridian COBRA Continuation Services, Attn: COBRA Benefits Administration, 3201 34th Street South, St. Petersburg, FL 33711. The form is available to participants when they become eligible for the COBRA premium reduction provisions under ARRA, and is also available on *www.ceridian-benefits.com*.

If you are denied treatment as an "Assistance Eligible Individual," you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction, go to *www.dol.gov/COBRA* or call 1-866-444-EBSA (3272).

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* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

HIPAA Special Enrollment Period

Summary of Material Modifications

This HIPAA Special Enrollment Period section of the booklet constitutes a Summary of Material Modifications (SMM) to the Pacific Gas and Electric Company FLEX Plan for Management Employees ("Plan"), effective April 2009.

In addition to being a Summary of Material Modifications, this HIPAA Special Enrollment Period section of the booklet replaces the HIPAA SPECIAL ENROLLMENT PERIOD and LOSS OF OTHER COVERAGE provisions on page B-I-7 of the Summary of Benefits Handbook for Management and Administrative & Technical Employees ("Handbook"). Unless otherwise noted, when reference is made to a different topic or section, the reference is to the Handbook, not this booklet.

Pacific Gas and Electric Company has the right to amend or terminate the Plan at any time and for any reason. Generally, an amendment to or termination of the Plan will apply prospectively and will affect your rights and obligations under the Plan prospectively.

HIPAA Special Enrollment Period

A HIPAA Special Enrollment Period may be available to you and your Eligible Dependents if 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 if the employer stops contributing towards 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

Effective April 1, 2009

- 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 the date of your marriage or domestic partnership registration, within 60 days of the birth, adoption or placement for adoption of a child, and 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 because:
  - of a legal separation (but only if it causes a loss of coverage);
  - of a divorce, death, termination of employment or reduction in hours;
  - dependent no longer meets eligibility requirements due to age or for other reasons;
  - you, or your Eligible Dependent Children, are covered by an HMO through your spouse's employer and you no longer reside in the HMO service area and have no other available plan option; or
  - the plan no longer offers benefits to similarly situated individuals.
- Termination of employer contributions under the other health care plan.
- The other health care coverage was through COBRA, and you have exhausted COBRA coverage.
- You meet or exceed a lifetime limit on all benefits under another health plan.

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

January 2009