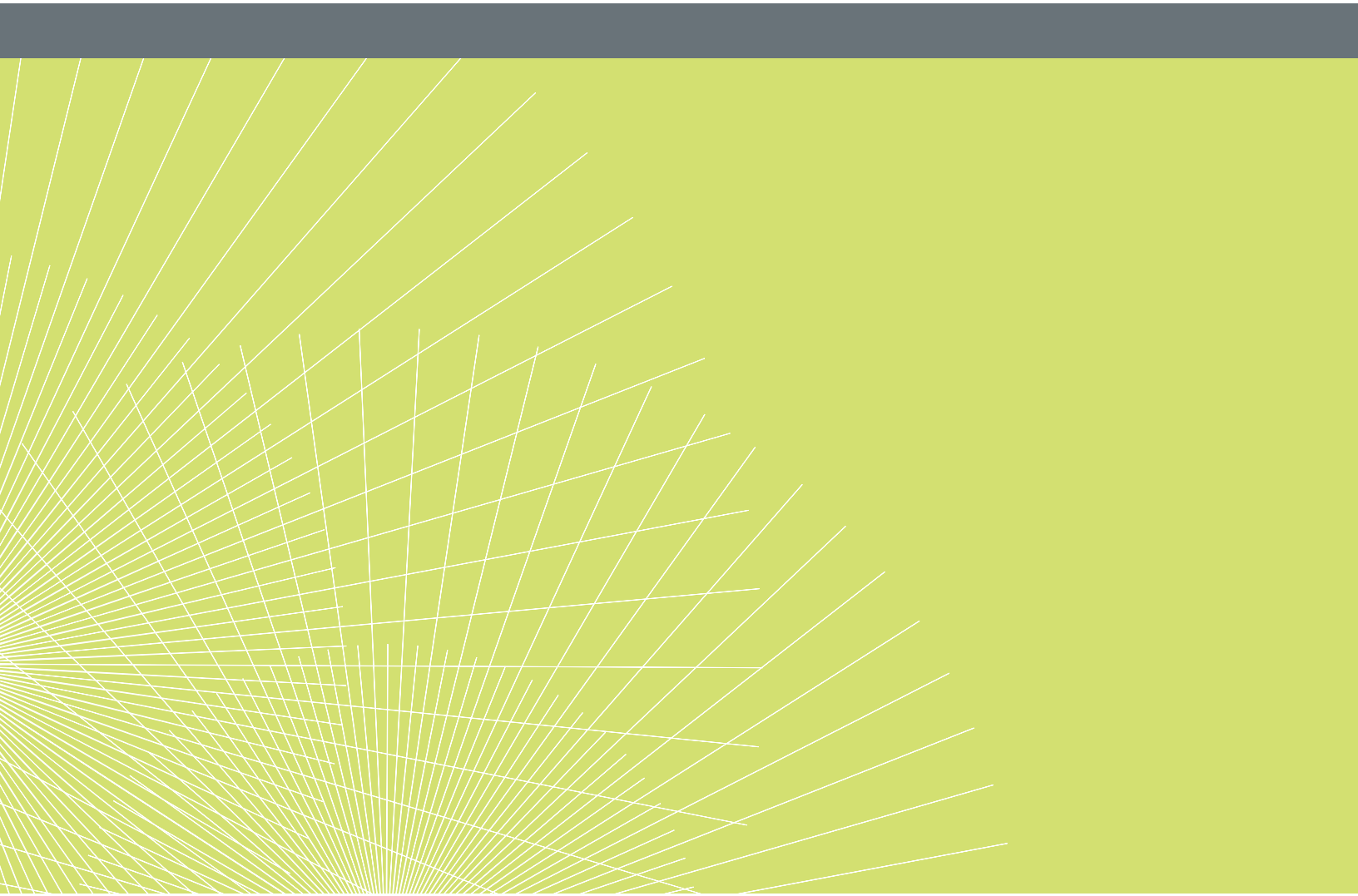
Live Bright

Benefits Enrollment Guide for Retirees and Surviving Dependents



This Benefits Enrollment Guide for Retirees and Surviving Dependents and the Supplement to Your 2009 Benefits Enrollment Guide (referred to collectively as the "Enrollment Guide") is designed, in part, to make you aware of important changes which have been made to The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents (referred to as the Health Care Plan). The Enrollment Guide is not an exhaustive explanation of the Health Care Plan. Additional information about the Health Care Plan is contained in the documents entitled The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, the Summary of Benefits Handbook and the Summaries of Material Modifications (SMMs) including enrollment guides designated as SMMs, as well as the Evidence of Coverage booklets issued by HMOs and the Anthem Blue Cross SmartValue Plan, which collectively constitute the official plan document.

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

Unless otherwise noted, references in this guide to PG&E mean Pacific Gas and Electric Company. Pacific Gas and Electric Company, PG&E Corporation and their affiliates are referred to collectively as "Participating Employers."

What's Inside

About this guide

This Benefits Enrollment Guide describes what's changing for 2009, your medical plan choices and how to enroll. For information on eligibility, change-in-status events, COBRA and other legally required information, see the enclosed Supplement to Your 2009 Benefits Enrollment Guide. **If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, please see page 10 in the Supplement for important information about your prescription drug coverage and Medicare.**

Live Bright

Take advantage of the health and wellness resources available to you and your family—and live bright. Living bright is all about using available wellness tools and resources, making healthy lifestyle choices and being informed about health issues overall. Remember, your health is your most important asset, and choices you make today can make a huge difference in the quality of your life.

Here's what PG&E offers to help you get started:

- **A wide range of medical plan choices**: Take the time to review this Enrollment Guide, understand your options and make the best choices for your situation.
- **Preventive care coverage**: All of our medical plan options cover exams and screenings at little or no cost to you. Be sure to get an annual physical, including cholesterol and blood pressure screenings. And mammograms, prostate cancer screenings and colonoscopies are critical, as well. Spending $10 now to check your blood pressure can save over $100,000 later on if you have a stroke, not to mention the impact on your quality of life.
- **Tools to help you stay healthy and manage your health care needs**: PG&E-sponsored medical plans also provide a variety of discounted services. Visit your plan's Web site or call the plan's Member Services department (see the inside back cover for contact information) to find out if your plan offers:
  - *Nurse advice lines*: Have symptoms or a medical question? These 24-hour telephone advice lines let you discuss medical issues with a nurse.
  - *Focused health programs*: Have diabetes, heart disease or asthma? Do you smoke? These programs provide personalized, ongoing assistance with these issues.
  - *Decision support*: Facing surgery? Have you received conflicting second opinions? These programs offer nurses and coaches backed by powerful databases to help you make informed decisions.
  - *Online health assessments*: These assessments provide advice to help you improve your health. Already consider yourself healthy? Many are surprised by how much they can do to get even more fit.
  - *Discounts on fitness club memberships*: Take advantage of special discounts if offered through your medical plan.

What's Changing

PacifiCare and Secure Horizons HMOs No Longer Available for Retirees Who Are Former ESC-Represented Employees

The PacifiCare Health Maintenance Organization (HMO) and its affiliated Medicare plan, Secure Horizons, will no longer be available to participants who are former ESC-represented employees for 2009 (this change became effective January 1, 2008, for former IBEW- and SEIU-represented employees and for non-union-represented retirees). In reviewing the medical plans, PG&E found that most PacifiCare doctors also participate in other medical plans offered by PG&E. Affected retirees and family members who are enrolled in PacifiCare and who do not elect a new medical plan for 2009 will be automatically enrolled in the Network Access Plan (NAP) or the Comprehensive Access Plan (CAP), as applicable to your ZIP code. Those who participate in Secure Horizons will be automatically enrolled in the CAP. See the medical plan comparison charts in this guide for more details.

New SmartValue Medicare Advantage Private Fee-for-Service Plan Available for Retirees Who Are Former ESC-Represented Employees

Effective January 2009, PG&E will offer a new, nationwide medical plan called the SmartValue Medicare Advantage Private Fee-for-Service (PFFS) Plan, or simply SmartValue, to retirees who are former ESC-represented employees (this plan was first offered in 2008 for non-union-represented retirees and former IBEW and SEIU-represented employees). The new plan is available to all Medicare-eligible members and dependents, as well as certain individuals with end-stage renal disease (ESRD). With no deductible and low copayments, the SmartValue plan—an Anthem Blue Cross insured plan—combines comprehensive benefit coverage with the flexibility to choose your own doctors and specialists. See page 16 for details or call SmartValue at 1-866-657-4970.

Other Medical Plan Changes

All medical plans make ongoing changes to providers and service areas. We suggest you verify service areas and provider availability directly using the plan's contact information provided on the inside back cover. The information in this guide is current as of October 2008, but subject to change.

You May Not Need to Enroll If You:

- *Want to keep the same medical plan and you have verified that the plan is still available in your area*
- *Want to stay in the plan you were automatically enrolled in if your current medical plan will no longer be available in 2009*
- *Do not need to add or delete dependents*
- *Will not be changing your Retiree Premium Offset Account (RPOA) election for the 2009 plan year*

Enrollment: What You Need To Do

You will need to make choices about which PG&E benefits you'd like to participate in during "Enrollment Windows." Enrollment windows are specific times that will require you to take action and select your benefits:

- During the annual Open Enrollment period (two weeks each year in the fall). Any changes you make during the Open Enrollment period become effective January 1 of the following year.
- When you experience an eligible change-in-status event, such as marriage. You must report any eligible change-in-status event to the HR Service Center within 31 days of the event (60 days for the birth or adoption of a child) in order to make any allowable changes to your benefits.

Each time an enrollment window occurs, use this guide to familiarize yourself with the most current information on PG&E's benefits programs and what coverage options are available to you. You can also use the information here to:

- Get ready to enroll
- Understand how you can enroll
- Know what to expect after you enroll.

Get Ready to Enroll

1. **Review your options, ask questions and talk with your family.** If you're thinking of changing medical plans or you are choosing for the first time:

   a. Check with your doctors to find out which plans they participate in.

   b. If you take any prescription medications regularly, contact the new plan to find out how these drugs are covered (for example, formulary or nonformulary drugs).

   c. Review the coverage offered for specific types of services that you and your family tend to use regularly, such as chiropractic care or urgent care.

   d. Verify service areas and provider availability, since all medical plans make ongoing changes during the year.

   To gather this information, call the medical plan's Member Services number or visit its Web site (shown on the inside back cover of this guide, along with medical plan group numbers, if applicable).

2. **Consider not only your current circumstances, but what may be happening in your life in the future.** Outside of the two-week Open Enrollment period, you will not be able to make changes to your benefits elections unless:

   a. You have an eligible change-in-status event.

   b. You move out of your provider service area.

   c. You or your dependent becomes eligible for Medicare or Medicaid.

   Note: If any of your primary care physicians, specialists, medical groups, Independent Practice Associations (IPAs), hospitals or other providers withdraw from your medical plan during 2009, you will not be able to change medical plans. Instead, you will need to obtain services from a participating provider within your plan's network for the remainder of the year. The withdrawal of a provider from your plan is not an eligible change-in-status event.

   See the section on page 7 for more information about reporting change-in-status events.

3. **Review your Enrollment Worksheet, showing your plan options and costs.** Many people make the mistake of choosing a plan based solely on the monthly premium. Think about which plan is the most cost-effective for you and best meets your health care needs at a total price you can afford. Here are some things to consider:

   a. **What the plans cover.** The comparison of medical benefits charts in this guide will help explain what each plan covers.

   b. **Your estimated usage.** Consider the services you use the most or will need in the future. Does your plan choice cover those services adequately?

   c. **Flexibility in choice of doctors, hospitals and how you receive care.** Each plan may include a different set of doctors or hospitals or have different rules for how to receive care.

   d. **How the plan coordinates with Medicare**. The way your plan coordinates with Medicare can impact the amount of paperwork required of you, what providers you can use and the total amount of coverage you receive.

4. **Confirm your Retiree Premium Offset Account (RPOA) balance, if applicable.** If you have an RPOA, see your most recent pension pay statement for your current account balance(s). You can use this information to estimate what your remaining RPOA balance will be on January 1, 2009. If your account balance is likely to be exhausted during 2009, you should take this into consideration when you enroll. You won't be

allowed to switch to a less expensive medical plan in the middle of the year if your RPOA balance is depleted during the year. See page 9 for details on RPOA.

5. **Review the eligibility provisions** on page 5 of the Supplement to Your 2009 Benefits Enrollment Guide. If your dependent is losing health plan eligibility, you must contact the HR Service Center at 415-972-7077 or 1-800-700-0057 within 31 days of the dependent's loss of eligibility. The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows you or your covered dependents to continue participation in company-sponsored medical plans beyond the normal period if coverage is lost due to a COBRA-qualifying event. See page 8 of the Supplement to Your 2009 Benefits Enrollment Guide for more information.

PG&E-sponsored medical plan vendors conduct an annual certification process for your enrolled dependents between the ages of 19 and 23. So, if you receive a letter from your medical plan vendor requesting dependent certification, you must complete the form and send it back to your plan as soon as possible. Otherwise, your child will be dropped from your health benefits and may not be reinstated until the next Open Enrollment period. For dependents who are disabled, you must contact the plan vendor directly to process the required certification before he or she turns 24. If you do not complete the certification on time, your disabled dependent can no longer be enrolled in the plan after the first of the month in which he or she turns 24.

You must drop ineligible dependents from coverage under PG&E-sponsored health plans within 31 days from the loss of eligibility. PG&E employees who cover ineligible dependents will be required to make restitution to the company for the associated cost of providing health care coverage, up to two full years of premiums or premium equivalents.

How to Enroll

As a retiree or surviving dependent, you have two options to enroll:

- Online through *PG&E@Work For Me* on the Internet. Enrolling online offers several advantages. It's secure, it's easy and it's fast. You can quickly access your benefit options and see your confirmation statement immediately after you've enrolled.
- Over the phone by calling the HR Service Center at 415-972-7077 or 1-800-700-0057. Representatives are available from 7:30 a.m. to 5:30 p.m. Pacific Time, Monday through Friday.

ENROLLING ONLINE

To access *PG&E@Work For Me* on the Internet from any computer with Internet Explorer (version 5.0, 6.0 and 7.0):

- Go to *https://myportal.pge.com*. If you're logging on for the first time, click the Help Guides link at the bottom of the page and follow the instructions to access the system.
- Choose the Open Enrollment tab

Then, follow the steps on page 6.

ENROLLING ONLINE CONT'D

Review your dependents	Make any necessary changes to your dependents. Have the following information on hand if you want to make changes: ◆ Full name, birth date, gender, Social Security number, relationship (for example, spouse, child, same-sex spouse or domestic partner) and Medicare claim number and effective date for any Medicare-eligible dependents (you can find this on the Medicare card). If you want to add a same-sex spouse/domestic partner and/or a same-sex spouse's/domestic partner's child(ren) to your plan, see page 5 of the Supplement to Your 2009 Benefits Enrollment Guide. If you want to remove a Medicare-eligible dependent, call the HR Service Center or send an e-mail to *hrbenefitsquestions@exchange.pge.com*.
Confirm your home address and phone number	If you regularly receive mail at a location other than your residence, you can add your mailing address from About Me > My Contact Info after you complete your benefits enrollment.
Select your benefit options (enroll)	Enroll in the benefit plan options available to you that best fit your needs and the needs of your family.
Review your confirmation statement	Verify the options you selected are shown on your confirmation statement. Your RPOA balance, if applicable, will also be shown. ◆ You can access your confirmation statement through *PG&E@Work For Me* on the Internet at any time after you enroll. ◆ If you enroll by telephone, you'll receive a confirmation statement mailed in December to your home address of record. If you find an error, call the HR Service Center within 10 business days at 415-972-7077 or 1-800-700-0057. All changes must be made in the current plan year. You cannot make changes based on an error on your confirmation statement in the following plan year.
Print your confirmation statement	Keep a copy of your statement for future reference.

If you decide to enroll in SmartValue, you must complete the *SmartValue Enrollment* form in addition to your Enrollment Worksheet. Please call the HR Service Center at 1-800-700-0057 to request a form, or you may access a copy online from *PG&E@Work For Me* on the Internet *(https://myportal.pge.com)*. You must complete and return this additional form to the HR Service Center by November 30, 2008, in order to complete your enrollment in SmartValue for 2009. Otherwise, you will remain enrolled in your current 2008 plan, or you will be enrolled in CAP if your plan is no longer available next year.

If You Don't Enroll

You will continue to receive your current 2008 medical coverage for yourself and your covered dependents, as listed on the enclosed 2009 Enrollment Worksheet (or the current medical plan shown on your worksheet, if your plan is being discontinued or will no longer be available in 2009).

Reporting Life Changes (change-in-status events)

If you marry, divorce or experience some other eligible change-in-status event, you have 31 days (60 days for the birth or adoption of a child) to make any allowable changes to your benefits. Otherwise, you may not be able to add dependents until the next Open Enrollment period. If you are adding a new eligible dependent(s) to your health coverage for the upcoming year during the Open Enrollment period, make sure you also add the dependent(s) to your health plans for the *current* year. See page 4 of the Supplement to Your 2009 Benefits Enrollment Guide for more details on eligible dependents.

Contact the HR Service Center at 415-972-7077 or 1-800-700-0057 to report any eligible change-in-status events or to ask questions about your benefits. Representatives are available from 7:30 a.m. to 5:30 p.m. Pacific Time, Monday through Friday.

Questions?

If you have questions about your benefit choices for 2009 or do not have Internet access, please call the HR Service Center at 415-972-7077 or 1-800-700-0057 for assistance. Or, send your question via e-mail to ***hrbenefitsquestions@exchange.pge.com****. Please allow one business day for a response.*

After You Enroll

Here's a quick look at what to expect after you enroll.

ID CARDS

If you change medical plans or add dependents, you'll receive your new medical plan identification card(s) in January 2009. If you don't receive your new ID card(s) by the end of January, call your medical plan directly. If you need to see a doctor before your ID card arrives, use your confirmation statement as proof of coverage. Members in the Anthem Blue Cross-administered plans (except SmartValue) and Health Net HMO plans can print a copy of their ID cards from the plan's Web site.

SELECTING PRIMARY CARE PHYSICIANS

You are not required to select a primary care physician (PCP) if you enroll in the Network Access Plan (NAP), Comprehensive Access Plan (CAP), Retiree Optional Plan (ROP), SmartValue Plan or Medicare Supplemental Plan (MSP). However, all of the HMOs and Medicare HMOs, except Kaiser Permanente, require that you and each of your covered dependents select a PCP from the plan's network of doctors. When you first enroll in one of these plans, the HMO will automatically assign a PCP to you and any dependents you enroll. You may select a different PCP upon receipt of your membership ID card(s) in January. Call your plan as soon as possible after you receive your ID card(s) and request that your PCP selection(s) be made retroactive to January 1, 2009. Each plan has its own policy and timeframe for changing primary care physicians retroactively.

For a directory of PCPs, call the Member Services number of the medical plan you're considering, or visit its Web site (listed on the inside back cover of this guide).

Re-Enrolling in PG&E-Sponsored Retiree Medical Coverage after Cancellation

Retirees who cancel medical plan coverage are allowed to re-enroll in a PG&E-sponsored medical plan only during a subsequent Open Enrollment period. To initiate re-enrollment, you must call the HR Service Center to request an Open Enrollment packet no later than September 1 of the year prior to the year for which you want to re-enroll. An enrollment packet will be mailed to your home immediately prior to Open Enrollment. Any coverage you elect during Open Enrollment will be effective the following January 1.

If you do not notify the HR Service Center by September 1, you will not be able to re-enroll for the upcoming year—even if you lose coverage elsewhere.

Please note that retirees who dropped PG&E-sponsored retiree medical plan coverage prior to January 1, 2003, are not eligible to re-enroll for PG&E-sponsored medical plan coverage.

In addition, surviving dependents who cancel medical plan coverage will not be able to enroll in a PG&E-sponsored medical plan at any time in the future.

Medical Plan Premium Contributions

Retiree Contributions

If you qualify for PG&E-sponsored retiree medical plan coverage, you and the Participating Employer (defined on the inside front cover of this guide) share the cost of coverage. The Participating Employer contributes a fixed amount, which is prorated for certain retirees with less than 25 years of credited service, as described on page 9. You are responsible for paying the remaining portion of the cost of coverage.

Participating Employer Contributions

The amount of the Participating Employer's contributions toward the cost of your coverage is based on your age, the age of your spouse or domestic partner (if applicable), whether you are covering any children, and your years of credited service.

- If you're under age 65, the Participating Employer's contribution is based on the year-2000 premium for PG&E's self-funded medical plan.
- If you're age 65 or older, the Participating Employer's contribution is based on the year-2000 premium for the PG&E Medicare Supplemental Plan.

The Participating Employer's contribution amounts are fixed—they will not increase over time.

Maximum Contribution

All retirees with 25 or more years of credited service receive 100 percent of the Participating Employer's fixed maximum contribution, as follows:

MAXIMUM MONTHLY PARTICIPATING EMPLOYER CONTRIBUTION FOR RETIREES UNDER AGE 65 WITH 25 OR MORE YEARS OF CREDITED SERVICE*	
Retiree Only	$262.91
Retiree + Spouse/Domestic Partner Under Age 65	$553.14
Retiree + Spouse/Domestic Partner Age 65 or Older	$429.75
Retiree + Children	$474.44
Retiree + Family (Spouse/Domestic Partner Under Age 65 + Children)	$765.03
Retiree + Family (Spouse/Domestic Partner Age 65 or Older + Children)	$692.88

* *If you retired with fewer than 25 years of credited service, these contribution amounts will be prorated, as described on this page.*

MAXIMUM MONTHLY PARTICIPATING EMPLOYER CONTRIBUTION FOR RETIREES AGE 65 OR OLDER WITH 25 OR MORE YEARS OF CREDITED SERVICE*	
Retiree Only	$87.07
Retiree + Spouse/Domestic Partner Under Age 65	$174.14
Retiree + Spouse/Domestic Partner Age 65 or Older	$174.14
Retiree + Children	$174.14
Retiree + Family (Spouse/Domestic Partner Under Age 65 + Children)	$261.21
Retiree + Family (Spouse/Domestic Partner Age 65 or Older + Children)	$261.21

* *If you retired after 2003 with fewer than 25 years of credited service, these contribution amounts will be prorated, as described on this page.*

Prorated Contribution

The Participating Employer's contribution to your cost of coverage is prorated if:

- You are under age 65 and retired with less than 25 years of credited service, or
- You are age 65 or older and retired after 2003 with less than 25 years of credited service.

Each full year of credited service qualifies you to receive 4 percent of the appropriate Participating Employer contribution listed above. Any fractional year of credited service qualifies you for a prorated portion of another 4 percent of the contribution.

Retiree Premium Offset Account (RPOA)

The Retiree Premium Offset Account (RPOA) is a PG&E benefit to help retirees reduce the amount they pay for PG&E-sponsored medical plan premiums. The RPOA benefit is not a medical plan, nor does the account have any cash value. Rather, it's a bookkeeping account containing credits that can be used to help eligible retirees offset, or reduce, their monthly PG&E-sponsored medical plan premium contributions. The RPOA is fully funded by PG&E, so it costs you nothing. There are two RPOAs: the RPOA50 and the RPOA25. Not all retirees who qualify for the RPOA50 qualify for the RPOA25.

RPOA50

All retirees who had at least 10 years of credited service are eligible for the RPOA50. The RPOA50 is a one-time allotment of $500 for each year of credited service beyond your first 10 years of credited service, up to a maximum of $7,500. If you were eligible and retired before 2004, you received your RPOA50 allotment in January 2004. If you retired after 2003, you received your RPOA50 at the time of retirement. You can use the RPOA50 to offset 50 percent of your monthly premium contributions, as long as you have a balance in your RPOA50 allotment.

RPOA25

If you retired on or before January 1, 2007, with 10 or more years of credited service, you may have received an additional RPOA allotment called the RPOA25. After you have depleted your initial RPOA50 allotment, you can use the RPOA25 to offset 25 percent of your PG&E-sponsored medical plan premiums. You cannot use your RPOA25 until your original RPOA50 has been depleted. If you are using the RPOA50 and you exhaust that balance, usage of your RPOA25 will automatically begin the month following the month in which your RPOA50 is exhausted.

Using Your RPOA

Each year during Open Enrollment, if you have a positive RPOA balance, you can elect to start, stop or continue using your RPOA to pay a portion of your medical plan premium contributions for the upcoming calendar year. (Please note that you must be enrolled in a PG&E-sponsored medical plan to take advantage of the RPOA.) Remember, you must exhaust your RPOA50 balance before using your RPOA25. Therefore, if you elect to use your RPOA benefit and you have a positive RPOA50 balance, you automatically will use the RPOA50 first. If you deplete your RPOA50 balance mid-year and you have an RPOA25 balance, you must begin using this balance the following month even if you would prefer to "save" it.

Making Changes

You may change your RPOA usage election for the upcoming year by indicating your election during the Open Enrollment period. If you don't request a change during Open Enrollment, your current RPOA usage election will remain in effect for 2009. After Open Enrollment ends, you may change your RPOA election during the year only if you have an eligible change-in-status event, as described in the enclosed Supplement to Your 2009 Benefits Enrollment Guide.

If your RPOA balance is depleted during the year, you will be responsible for paying the full amount of your medical plan premium contributions through the end of the year. You will not be allowed to switch to a less expensive medical plan during the year if your RPOA benefit is depleted.

Surviving Dependent Contributions

Surviving dependents pay the full cost of their medical plan premiums. However, they may "inherit" an RPOA balance if they became surviving dependents on or after January 1, 2004, the retiree was eligible for the RPOA, and the RPOA balance has not been depleted.

Calculating Your Contributions

Your monthly medical plan premium contribution is the difference between the full cost of coverage for the plan in which you're enrolled and the amount the Participating Employer contributes. Since the cost of coverage for most medical plans in 2009 is more than the amount the Participating Employer contributes, participants in most plans will be required to pay a monthly premium contribution.

However, if you have an RPOA balance, you may use the account to reduce your monthly premium contribution. The examples on the next page show how your monthly contribution amount is calculated—both with and without the RPOA election.

Sample 2009 Monthly Premium Calculations

RETIREE* + SPOUSE BOTH OVER 65 AND IN COMPREHENSIVE ACCESS PLAN (CAP)

EXAMPLE 1 WITH RPOA50	
Monthly Premium	$633.98
Participating Employer Fixed Contribution	– $174.14
Retiree Premium Contribution (without RPOA50)	$459.84
RPOA50 Election (50 percent of premium contribution without RPOA)	– $229.92
Retiree's Monthly Premium Contribution (with RPOA50)	$229.92

EXAMPLE 2 WITH RPOA25	
Monthly Premium	$633.98
Participating Employer Fixed Contribution	– $174.14
Retiree Premium Contribution (without RPOA25)	$459.84
RPOA25 Election (25 percent of premium contribution without RPOA)	– $114.96
Retiree's Monthly Premium Contribution (with RPOA25)	$344.88

EXAMPLE 3 WITHOUT RPOA	
Monthly Premium	$633.98
Participating Employer Fixed Contribution	– $174.14
Retiree Premium Contribution (without RPOA)	$459.87
No RPOA Election (0 percent of premium contribution without RPOA)	$0.00
Retiree's Monthly Premium Contribution (without RPOA)	$459.87

* *Assumes retiree with 25 years of credited service or more.*

You may notice that the cost of covering a spouse or domestic partner who is under age 65 may be higher than the cost of covering a Medicare-eligible spouse or domestic partner. This is because the Participating Employer's fixed contributions to the cost of coverage are based on the age of the retiree, but the cost of the medical plan is based on the Medicare eligibility of both the retiree and his or her spouse or domestic partner. Since premiums are higher for spouses or domestic partners who are not eligible for Medicare, but the Participating Employer's contributions are the same, regardless of Medicare eligibility, your costs will be higher.

Managing Premium Increases

Annual increases in your cost of coverage are the result of increasing medical plan premiums. Retirees absorb the entire cost of premium increases, since the Participating Employer's contribution is fixed. Therefore, your percentage cost increase will be greater than the plan's percentage cost increase, as shown in the illustration below.

NAP MONTHLY COSTS FOR RETIREE* AND SPOUSE BOTH UNDER AGE 65			
	2008 NAP	***2009 NAP***	***Cost Increase***
Total Monthly Cost	$1,157.00	$1,216.97	5.2%
Participating Employer Contribution	– $553.14 (frozen)	– $553.14 (frozen)	N/A
Retiree's Monthly Cost	$603.86	$663.83	9.9%

* *Assumes retiree with 25 years of credited service or more.*

Medicare Part B Reimbursement for Disabled Retirees Under Age 65

In 2009, the Participating Employers will continue to reimburse the standard Medicare Part B premium each month to eligible disabled retirees and any of their disabled dependents who are under age 65 and qualify for Social Security.

If you're under age 65 and you believe you or any of your dependents qualify for Social Security due to a disability, please contact Allsup, Inc., at 1-888-339-0743. PG&E has contracted with Allsup, Inc. to provide Social Security enrollment assistance at no cost to potentially qualified disabled retirees or dependents.

Once enrolled in Medicare, you must provide your Medicare claim number and Medicare effective date to PG&E.

Check Out Your Health Plan's Web Site

Use the provider Web sites (listed on the inside back cover) to:

- *Learn about health and wellness topics, such as fitness and nutrition*
- *Find out how your hospital or doctors rank in quality compared to their peers*
- *Confirm eligibility for yourself and your dependents*
- *Request new or replacement ID cards*
- *Check the status of your claims*
- *Search for providers and switch primary care physicians*
- *Get wellness discounts*
- *Check drug formulary information or order refills*
- *Download and print forms.*

Savings Tip

- *Consider the SmartValue Medicare Advantage Private Fee-for-Service (PFFS) plan available to all Medicare members. This plan also has lower premiums than NAP or CAP and is available nationwide.*
- *Consider the Retiree Optional Plan (ROP). The ROP has lower monthly premiums than the NAP and CAP. Although ROP coverage is less comprehensive than that of other plans, it still provides substantial benefits in the event of a major illness. See page 24 for details.*
- *Consider one of the HMO options available to you. PG&E offers several HMOs with lower premiums than the NAP and CAP. HMOs are available only in certain areas of California, so check your 2009 Enrollment Worksheet for your options.*
- *Find out if health care coverage is available to you through a current employer or your spouse/domestic partner. If it is, review your coverage options to make the best choice for you and your family. See Re-enrolling in PG&E-Sponsored Retiree Medical Coverage After Cancellation on page 8 for more information.*

Medical Plan Monthly Premium Contributions

For Members Over Age 65 and on Medicare, with 25 Years or More of Credited Service*

Please refer to your 2009 Enrollment Worksheet to see which plans you are eligible to join.

OVER-65 MEDICAL PLAN OPTION(S)	*Retiree Only*	*Retiree Plus Spouse / DP Under 65*	*Retiree Plus Spouse / DP Over 65*	*Retiree Plus Child(ren)*	*Retiree Plus Family (Spouse / DP Under 65)*	*Retiree Plus Family (Spouse / DP Over 65)*	*Surviving Dependent Over 65*	*Surviving Dependent Over 65 Plus Child(ren)*
CAP Plan (Medicare Supplemental Plan)	$229.92	$780.31	$459.84	$606.46	$1,156.85	$836.38	$316.99	$780.60
PG&E Medicare Supplemental	$114.09	$664.48	$228.18	$490.63	$1,074.79	$604.72	$201.16	$664.77
Retiree Optional Plan (ROP)	$21.44	$338.04	$42.88	$227.94	$544.54	$249.38	$108.51	$402.08
Anthem Blue Cross SmartValue Medicare Advantage Plan	$147.85	$698.24	$295.75	$524.39	$1041.02	$672.29	$234.97	$698.59
Blue Shield Medicare COB HMO	$346.60	$795.56	$693.24	$649.37	$1,098.33	$996.01	$433.72	823.56
Health Net Seniority Plus (Medicare HMO)	$183.91	$704.00	$367.87	$538.40	$1,058.49	$722.36	$271.03	$712.59
Health Net Medicare COB HMO	$301.04	$821.13	$602.13	$655.53	$1,175.62	$956.62	$388.16	$829.72
Kaiser Permanente Senior Advantage North or South (Medicare HMO)	$200.23	$626.54	$400.46	$486.54	$912.85	$686.77	$287.30	$660.68

* *The company contribution will be prorated for retirees who retired after 2003 with less than 25 years of credited service. Please refer to your 2009 Enrollment Worksheet to see your actual premium contribution amount.*

These rates do not include the Medicare Part B refund for Medicare members.

DP = Registered Domestic Partner. Please note, surviving dependents cannot enroll a spouse or domestic partner in PG&E-sponsored medical plans. See page 5 in the Supplement to Your 2009 Benefits Enrollment Guide for more details.

For Members Under Age 65 and not on Medicare, with 25 Years or More of Credited Service*

Please refer to your 2009 Enrollment Worksheet to see which plans you are eligible to join.

UNDER-65 MEDICAL PLAN OPTION(S)	*Retiree Only*	*Retiree Plus Spouse / DP Under 65*	*Retiree Plus Spouse / DP Over 65*	*Retiree Plus Child(ren)*	*Retiree Plus Family (Spouse / DP Under 65)*	*Retiree Plus Family (Spouse / DP Over 65)*	*Surviving Dependent Under 65*	*Surviving Dependent Under 65 Plus Child(ren)*
NAP or CAP Plan	$316.60	$663.83	$466.75	$568.68	$915.55	$667.23	$637.46	$1,101.07
With Medicare-eligible spouse/ DP enrolled in Anthem Blue Cross SmartValue Plan			$384.73			$585.21		
Retiree Optional Plan	$104.06	$217.50	$45.73	$186.10	$299.18	$76.17	$403.67	$697.24
Blue Shield HMO	$224.40	$470.20	$491.27	$402.71	$648.15	$617.98	$487.80	$877.64
Health Net HMO	$289.04	$605.97	(see below)	$519.07	$835.64	(see below)	$607.16	$1,048.72
With Medicare-eligible spouse/ DP enrolled in Health Net Medicare COB HMO			$510.36			$688.79		
With Medicare-eligible spouse/ DP enrolled in Health Net Seniority Plus			$393.23			$571.66		
Kaiser Permanente North or South	$203.80	$426.95	$324.26	$365.65	$588.44	$434.51	$467.09	$840.47

* *The company contribution will be prorated for retirees with less than 25 years of credited service. Please refer to your 2009 Enrollment Worksheet to see your actual premium contribution amount.*

If Medicare is the primary payer for you or a dependent, your required premiums may be less than what is stated above. Refer to your 2009 Enrollment Worksheet to see your actual premium contribution amount.

These rates do not include the Medicare Part B refund for Medicare members.

DP = Registered Domestic Partner. Please note, surviving dependents cannot enroll a spouse or domestic partner in PG&E-sponsored medical plans. See page 5 in the Supplement to Your 2009 Benefits Enrollment Guide for more details.

Medical Plan Options For Medicare-Eligible Members

Before you make a decision about your medical coverage, it is important to understand the differences between the Comprehensive Access Plan (CAP), the SmartValue Medicare Advantage Private Fee-for-Service (PFFS) Plan, the PG&E Medicare Supplemental Plan (MSP), the Retiree Optional Plan (ROP), Medicare Coordination of Benefits (COB) HMO Plans and Medicare Advantage HMOs.

Following is a brief summary of how the different types of plans work. For additional information, see the Comparison of Medical Benefits charts beginning on page 22.

Comprehensive prescription drug coverage is included in all the medical plans PG&E sponsors. However, there is no direct coordination of benefits with Medicare on prescription drugs. The following summaries also describe how your prescription drug plan integrates with the federal Medicare Part D benefits. Every plan that PG&E offers to Medicare-eligible participants has a higher prescription drug benefit than the basic Part D benefit.

IMPORTANT: Do not enroll in any Medicare Advantage plan or Medicare Part D Prescription Drug Plan (PDP) that is not sponsored by PG&E. Since you would be assigning your Medicare benefits to a plan that is not sponsored by PG&E, enrolling in an external plan would cause you to be disenrolled from your PG&E-sponsored medical coverage. See page 4 of the Supplement to Your 2009 Benefits Enrollment Guide for details on prescription drug coverage and Medicare.

Comprehensive Access Plan (CAP)

For medical, Medicare is primary, and this plan provides Medicare secondary coverage, plus primary prescription drug coverage. This means Medicare processes your claims first (except prescription drug claims, which are covered directly through Medco Health), and the CAP processes your claims second. The CAP pays only the difference necessary to make your total reimbursement (Medicare's payment plus the CAP's payment) equal to the amount a non-Medicare member would receive. You may still be required to pay part of the claim.

EXAMPLE: Medicare covers laboratory services at 80 percent, while CAP allows for total coverage of 90 percent. Therefore, CAP will pay the 10 percent difference between 90 percent and 80 percent for lab claims. You would be responsible for paying the remaining 10 percent of the claim.

Attention: Current Secure Horizons Members

In 2009, Secure Horizons will be eliminated from the group of plans PG&E sponsors. You must join a new medical plan if you are currently enrolled in Secure Horizons. And, since all of your medical and prescription drug benefits are currently assigned to Secure Horizons, you will be required to sign a disenrollment form to get your Medicare benefits back, unless you decide to join another Medicare Advantage HMO. Otherwise, Secure Horizons may assign you to its individual Secure Horizons plan, which is not sponsored by PG&E.

After enrolling, you will be sent a Medicare HMO Disenrollment *form, if applicable. See page 20. If you do not select another medical plan, PG&E will default you to the CAP for 2009. However, if you do not get back your Medicare benefits from Secure Horizons by signing a disenrollment form, you may be responsible for paying medical costs that Medicare typically pays.*

If you are Medicare-eligible, CAP will pay this reduced amount, even if you haven't enrolled in Medicare. **To receive full benefits, be sure to enroll promptly in both Parts A and B of Medicare as soon as you become eligible.**

The plan provides coverage worldwide, so care may be received from the physician or hospital of your choice. There is no network of providers, and you are not required to choose a primary care physician or go to a network provider to receive the highest level of benefits. For families with both Medicare and non-Medicare members, non-Medicare members are enrolled in NAP and should use Anthem Blue Cross network providers to receive the higher network level of benefit coverage.

CAP, ROP and MSP Medicare members are not enrolled in a Medicare Part D prescription drug plan (PDP). CAP members remain in the same Prescription Drug Plan as non-Medicare CAP and NAP members via Medco. ROP and MSP members are also enrolled via Medco, but have different levels of coverage than CAP members. These coverages are outlined on pages 40 to 41. The prescription drug benefits offered to CAP members are considered actuarially better than those provided under basic Part D benefits. Your medical plan premium contributions have been reduced by the estimated amount of subsidy received by PG&E from the federal government for providing you the actuarially approved benefits.

Because the prescription drug benefits of these plans are better, you won't be assessed a late enrollment penalty should you later decide to enroll in a Part D plan. However, you may have to provide a copy of your Notice About Your Prescription Drug Coverage, included in the enclosed Supplement to Your 2009 Benefits Enrollment Guide, to any potential future Medicare Part D insurer as proof of this "creditable coverage" through PG&E. Please make sure that you do not enroll in a Medicare Part D plan that is offered outside of PG&E. If you do so, you will be disenrolled from the PG&E plans.

NEW! SmartValue Medicare Advantage Private Fee-for-Service Plan Available to Retirees Who Are Former ESC-Represented Employees

Effective January 2009, PG&E will offer a new, nationwide medical plan called the SmartValue Medicare Advantage Private Fee-for-Service (PFFS) Plan to retirees who are former ESC-represented employees (this change became effective January 1, 2008, for non-union-represented retirees and former IBEW- and SEIU-represented employees). Members and their dependents who live in the United States and who are enrolled in Medicare Parts A and B are eligible to enroll in the SmartValue plan. (Note: Some individuals with end-stage renal disease (ESRD) may be ineligible to enroll. Please call SmartValue to see if you are eligible to participate.) With no deductible and low copayments, the SmartValue plan—an Anthem Blue Cross insured plan—combines comprehensive benefit coverage with the flexibility to choose any doctor or specialist who accepts SmartValue.

For summary information, see the chart on pages 32 to 33.

As with Medicare Advantage HMO plans, when you join this plan, you assign your Medicare benefits to the insurer, which is the SmartValue plan. By doing so, you agree to have Anthem Blue Cross process all claims and to use only providers that have agreed to accept the terms and conditions of the SmartValue plan. You also agree to use the Anthem Blue Cross-WellPoint Medicare Part D Drug Program for your prescription drug needs.

The way the SmartValue Medicare Advantage PFFS Plan works is unique. By federal law, a PFFS plan is not currently required to have a network of contracted providers. You can choose to go to any Medicare-approved doctor, specialist or hospital in the nation that accepts Medicare and agrees to accept the terms of the SmartValue plan. Each provider is allowed to tell Anthem Blue Cross that it does not want to work with the SmartValue plan. However, unless a provider says "no" to the SmartValue plan, that provider is automatically deemed to have accepted

the SmartValue plan. Typically, about 90 to 95 percent of all providers nationally accept Medicare. The SmartValue plan allows you the flexibility to use any of these providers, including specialists without having to obtain a referral, as long as they agree to accept the terms of the plan. And, if you have an emergency, the SmartValue plan will cover you for the emergency care, even if the provider does not accept SmartValue, or if you are traveling outside of the United States.

With SmartValue, your prescription drug benefits are automatically provided through the Anthem Blue Cross Medicare Part D Drug Program. (Unlike other Anthem Blue Cross-administered plans, SmartValue uses the Anthem Blue Cross WellPoint pharmacy, not the Medco pharmacy). The SmartValue drug plan is considered an "enhanced" Medicare Part D plan. This means it has better benefits than the standard Medicare Part D plan, without any deductibles or gaps in coverage. The plan does require a formulary; see the chart on page 33. If you join this plan, you may be required to switch pharmacies, although most of the nation's retail chain drug stores currently accept SmartValue members. Before enrolling, be sure to research the level of coverage SmartValue provides for the specific prescription drugs you use, as well as your pharmacy options, by calling 1-866-657-4970.

If you choose SmartValue, any of your family members who are not Medicare-eligible will be enrolled in either NAP or CAP, as appropriate for your ZIP code, with prescription drug benefits through Medco.

Please note that you will not be allowed to change to another medical plan sponsored by PG&E in 2009 if you enroll in SmartValue and later decide you want to cancel coverage midyear, unless you experience an eligible change-in-status event which allows for such a change. See page 6 in the Supplement to Your 2009 Benefits Enrollment Guide for more information on eligible change-in-status events.

If you have any questions regarding this plan, please call SmartValue at 1-866-657-4970 to speak with a representative.

Important

If you decide to enroll in SmartValue, you must complete the SmartValue Enrollment *form in addition to your Enrollment Worksheet. Please call the HR Service Center at 1-800-700-0057 to request a form, or you may access a copy online from* PG&E@Work For Me *on the Internet (https://myportal.pge.com). You must complete and return this additional form to the HR Service Center by November 30, 2008, in order to complete your enrollment in SmartValue for 2009. Otherwise, you will remain enrolled in your current 2008 plan, or you will be enrolled in CAP if your plan is no longer available next year.*

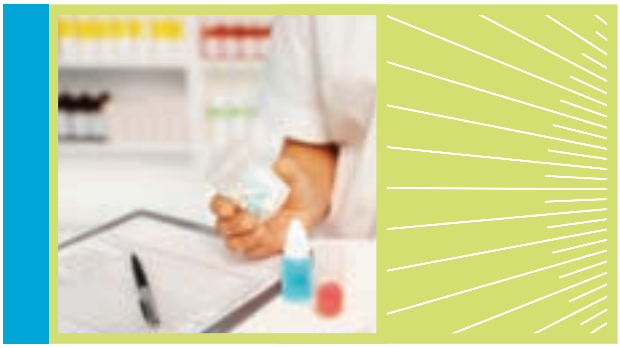
Retiree Optional Plan (ROP)

This plan provides Medicare secondary coverage, plus primary prescription drug coverage. Claims are processed similarly to the CAP which means if you have Medicare, Medicare will pay primary and the ROP pays second for claims other than prescription drug claims. Prescription drug claims are processed directly through Medco. The ROP has a lower monthly premium cost than the other self-funded medical plans administered by Anthem Blue Cross, although it has higher out-of-pocket costs when services are actually used. Like all of the other medical plans, the ROP offers comprehensive coverage in the event of a major illness and protects members against catastrophic costs.

Like the CAP, the ROP pays only the difference necessary to make your total reimbursement (Medicare's payment plus the ROP's payment) equal to the amount a non-Medicare member would receive. You may still be required to pay part of the costs of the services provided.

EXAMPLE: Medicare covers laboratory services at 80 percent, while the ROP covers only 70 percent. Therefore, the ROP will not make any payment after Medicare processes the claim at 80 percent. You would be responsible for paying the remaining 20 percent of the claim.

Because Medicare members are billed at Medicare's preferred rates, you may use any provider nationwide without having your benefits reduced. If you have non-Medicare dependents, they may want to use Anthem Blue Cross network providers to take advantage of discounted, contracted rates that lower coinsurance amounts and protect against charges for expenses above "reasonable and customary" amounts.



Medicare Supplemental Plan (MSP)

This plan provides Medicare secondary coverage, plus primary prescription drug coverage. Claims, other than prescription drug claims, are processed first by Medicare, then the MSP pays 80 percent of eligible expenses not paid by Medicare once you satisfy a $100 deductible. Prescription drug claims are processed directly through Medco. The MSP is available only to retired employees on Medicare and their covered dependents who also have Medicare. The non-Medicare-eligible dependents of MSP members will be enrolled in NAP or CAP, as appropriate for their ZIP code.

EXAMPLE: Medicare covers laboratory services at 80 percent. If your annual deductible has been met, the MSP will pay 80 percent of the remaining 20 percent, or 16 percent of the claim. You would be responsible for paying the remaining 4 percent of the claim.

The MSP has a $10,000 lifetime maximum medical plan benefit for each member and a separate $10,000 lifetime maximum for prescription drugs; however, every January, the plan "restores" up to $1,000 toward each of these two maximums. Be sure to take into consideration how close you are to reaching these two maximums before remaining enrolled in the MSP.

If you are enrolled in the MSP and reach your lifetime maximum at any time during the plan year, you may choose another plan in your ZIP code/service area. Call the HR Service Center if you are notified by either Anthem Blue Cross or Medco that you have exhausted your $10,000 lifetime maximum.

Blue Shield and Health Net Medicare Coordination of Benefits HMO Plans

This type of plan provides medical care through the HMO's network of physicians and hospitals, and you pay designated copayments for the services that you receive from the HMO. In general, the HMO will coordinate all payments with Medicare, and you will not be responsible for any additional payments beyond the designated copayments. This plan gives you the option to seek coverage through the HMO's network of physicians and hospitals or to go outside the HMO network and receive traditional Medicare coverage at the standard level of Medicare benefits.

Enrollment in a Medicare Coordination of Benefits (COB) HMO plan requires members to be enrolled in Medicare Parts A and B. By enrolling in one of these plans, you will also be enrolling in the HMO's Medicare Part D prescription drug coverage. This Part D prescription drug plan is considered an "enhanced" Medicare Part D plan. This means that the plan has better benefits than the standard Medicare Part D plan, without any deductibles or gaps in coverage. You should not enroll in Medicare Part D through a separate Prescription Drug Plan (PDP) outside of PG&E.

The Medicare COB HMO plans require new enrollees to complete an enrollment application for the Medicare Part D prescription drug coverage. An application will be sent to you from PG&E, and the completed/signed form must be returned back to PG&E before your enrollment can become effective. Members who enroll but who do not have Medicare Parts A and B, or who do not agree to enroll in the HMO's Medicare Part D coverage, cannot join the plan and instead will be switched to the Comprehensive Access Plan (CAP) administered by Anthem Blue Cross.

Please note that you will not be allowed to switch to another medical plan sponsored by PG&E midyear unless you move out of the HMO's service area.

Medicare Advantage HMO Plans

The Medicare Advantage HMOs offered through PG&E include Kaiser Permanente Senior Advantage (North and South) and Health Net Seniority Plus. A Medicare Advantage HMO operates like a Medicare COB HMO plan (see page 36), except it allows you to seek coverage only through the Medicare HMO's network of physicians and hospitals and requires that you assign or "give away" your Medicare benefits to the HMO. By doing so, you can no longer use your Medicare benefits outside of the Medicare Advantage HMO network. However, the premiums for Medicare Advantage HMO plans are typically lower than those for Medicare COB HMO plans.

If you enroll in a Medicare Advantage HMO plan, you will automatically be enrolled in the Medicare HMO's Part D prescription drug coverage, which is included as part of the Medicare Advantage HMO's benefits. These drug plans are considered "enhanced" Medicare Part D plans. This means that these plans have better benefits than the standard Medicare Part D plan, without any deductibles or gaps in coverage. You should not enroll in Medicare Part D through a separate Prescription Drug Plan (PDP) outside of PG&E.

If you are currently enrolled in a Medicare Advantage HMO and would like to switch to an Anthem Blue Cross-administered plan or a Medicare COB HMO, you must complete a *Medicare HMO Disenrollment* form to get back the full use of your Medicare benefits. (See page 20 for more information on disenrolling from a Medicare HMO.)

Please note that you will not be allowed to switch to another medical plan sponsored by PG&E midyear unless you move out of the HMO's service area.

Important Enrollment Information for Medicare-Eligible Members

FOR ALL OF THE PLANS

It is important for you and your dependents to enroll in Medicare Parts A and B as soon as you or your dependents are eligible. You are usually enrolled automatically in Medicare Part A, which covers hospitalization at no cost to you, when you apply for Social Security benefits. However, you need to contact the Social Security Administration to enroll in Part B coverage, which covers doctor's office visits and certain other expenses. You will pay a separate premium to the Social Security Administration for Part B coverage. If you do not retain both Medicare Parts A and B coverage for yourself and your Medicare-eligible dependents, your PG&E-sponsored medical plan will not pay the charges that would have otherwise been covered by Medicare, and you will not be eligible to enroll in a Medicare COB HMO plan, a Medicare Advantage HMO plan or the SmartValue Medicare Advantage Private Fee-for-Service (PFFS) Plan.

FOR MEDICARE ADVANTAGE HMO PLANS

When you first enroll in a Medicare Advantage HMO, a primary care physician (PCP) will be assigned to you and any dependents you enroll. You may select a different PCP by contacting your plan's Member Services department when you receive your membership ID card(s) in January.

The PCP(s) you select must be from the Medicare Advantage HMO's special network, which may be different than the plan's network of doctors for members not enrolled in its Medicare Advantage HMO. The PCP must be located within 30 miles of your home. If this requirement is not met, the Medicare Advantage HMO will assign a PCP who is within a 30-mile radius.

Please note that:

- Kaiser Permanente Senior Advantage members do not need to designate a primary care physician.

- You must sign a *Medicare Advantage HMO Enrollment* form. This form authorizes assignment of your Medicare benefits (Parts A and B) to the HMO and acknowledges your understanding that you will be enrolled in Medicare Part D through the HMO. When you enroll, the HR Service Center will send you the appropriate form to complete and return. If you do not receive the form within two weeks, you should call the HR Service Center to inquire about the status of the form.
- You must have enrolled yourself and any eligible dependents in Medicare Parts A and B.

If you do not meet these requirements or complete the *Medicare Advantage HMO Enrollment* form, you won't be able to join the Medicare Advantage HMO. Instead, your medical coverage will default to the CAP, and you will be responsible for the premium contributions for that plan.

DISENROLLING FROM MEDICARE ADVANTAGE PLANS, INCLUDING SECURE HORIZONS AND SMARTVALUE

When you disenroll from a Medicare Advantage plan and enroll in a different type of medical plan—for example, if you switch to the CAP, ROP, MSP or a Medicare COB HMO during Open Enrollment—you must complete a *Medicare HMO Disenrollment* form. This is a mandatory step in the disenrollment process and is necessary to ensure you receive maximum benefits and avoid unpaid claims after you switch plans. After electing to change plans, you will be sent a disenrollment form, specific to the Medicare Advantage plan in which you are currently enrolled, to complete and return to the HR Service Center *no later than November 30, 2008*. If, for some reason, you do not receive a disenrollment form within two weeks of your enrollment change, you should call the HR Service Center to inquire about the status of the form.

Savings Tip

Using generic, mail-order and "brand formulary" drugs can save you money.

A formulary is a list of prescription drugs that a medical plan covers, and it can be either open or closed. Most HMOs and the SmartValue plan use a three-tier cost approach to prescription drugs.

- *The lowest-cost drug is typically the generic drug. Generic drugs are considered chemically equivalent to brand-name drugs. Generic drugs go by the FDA-approved chemical name, not by the trademark name that you see in advertisements.*
- *The middle-cost tier is brand formulary drugs. These drugs have trademarked names. They are selected as preferred drugs from a family of prescription drugs, because the health plan receives favorable pricing from the manufacturer. For example, there are a number of drugs that treat acid reflux in a similar way. One of the drugs might be the preferred brand formulary drug, while the others will be nonformulary drugs. You'll typically pay less if you select the formulary drug.*
- *The highest-cost tier is the nonformulary drug. These drugs typically cost your health plan the most, so you end up paying more, as well.*

The medical plans that PG&E offers don't cover every prescription drug, and some prescriptions may require special authorization from your medical plan before they can be filled. For information about a specific drug, call your medical plan's Member Services department or visit its Web site. Contact information is listed on the inside back cover of this guide.

How Medicare Eligibility Affects Your Medical Plan Options

PG&E offers a variety of medical plans based on where you live. Some plans provide different benefits for their members after they turn age 65 and/or become Medicare-eligible. The plan names may even change. For example, Health Net's corresponding Medicare Advantage HMO plan is called Seniority Plus.

Review your 2009 Enrollment Worksheet for the specific plans available to you. Then, review the chart below to determine the corresponding medical plan available to any dependent(s) whose eligibility for Medicare is different than your own. Don't forget to check the monthly premium contributions for each plan, which are listed on your 2009 Enrollment Worksheet.

EXAMPLE: You are eligible for Medicare, but your spouse and children are not. You elect to enroll in the Health Net Seniority Plus plan. Your spouse and children will be enrolled in the Health Net HMO plan.

Please review the Comparison of Medical Benefits charts on pages 30 to 39 to see the specific benefits offered by each plan.

NON-MEDICARE PLANS*	CORRESPONDING PLAN FOR MEDICARE-ELIGIBLE MEMBERS*
Network Access Plan (NAP) or Comprehensive Access Plan (CAP)	Comprehensive Access Plan (CAP), Medicare Supplemental Plan (MSP) or Anthem Blue Cross SmartValue Medicare Advantage PFFS Plan
Retiree Optional Plan	Retiree Optional Plan
Blue Shield HMO	Blue Shield Medicare Coordination of Benefits (COB) HMO Plan
Health Net HMO	Health Net Seniority Plus (Medicare Advantage HMO) or Health Net Medicare Coordination of Benefits (COB) HMO Plan
Kaiser Permanente North and South HMO	Kaiser Permanente Senior Advantage North and South (Medicare Advantage HMO)

* *Plans are subject to availability, based on your home ZIP code.*

Comparison Of Medical Benefits For Members Under 65

The information in this chart is intended as a high-level summary only. The information contained in an applicable service provider agreement between PG&E and Anthem Blue Cross shall govern in case of conflict between this chart and the service provider agreement.

PROVISIONS	NETWORK ACCESS PLAN (NAP) ADMINISTERED BY ANTHEM BLUE CROSS	
	Network	***Non-Network***
General	Care provided by network providers; $100 annual deductible per individual, up to family maximum of $300; annual out-of-pocket maximum of $750 per individual, up to family maximum of $1,500 (includes deductible); no lifetime maximum on benefits; no pre-existing condition exclusions	Care provided by non-network providers; $200 annual deductible per individual, up to family maximum of $600; annual out-of-pocket maximum of $1,000 per individual, up to family maximum of $2,000 (includes deductible); no lifetime maximum on benefits; no pre-existing condition exclusions. All plan benefits and out-of-pocket maximums are based on Eligible Expenses only*
Hospital Stay	100% after $100 copay; preauthorization required for nonemergency care, $300 penalty if not obtained; covers semiprivate room (private if Medically Necessary); includes intensive care	70%; preauthorization required for nonemergency care, $300 penalty if not obtained; covers semiprivate room (private if Medically Necessary); includes intensive care
Skilled Nursing Facility	90% for semiprivate room after 3 days in hospital; preauthorization required, $300 penalty if not obtained; excludes custodial care	70% for semiprivate room after 3 days in hospital; preauthorization required, $300 penalty if not obtained; excludes custodial care
Outpatient Hospital and Emergency Room Care	100% after $35 copay for medical emergency or outpatient surgery; waived if admitted	100% after $35 copay for medical emergency, waived if admitted; 70% for outpatient surgery
Office Visits	Primary care—100% after $10 copay; Specialist (including OB/GYN)—100% after $20 copay	70%
Urgent Care Visits	Primary care—100% after $10 copay; Specialist (including OB/GYN)—100% after $20 copay	70%
Routine Physical Examinations	Primary care—100% after $10 copay; Specialist—100% after $20 copay; lab/X-ray covered separately	70%
Immunizations and Injections	95%	70%
Eye Examinations	Not covered	Not covered
X-rays and Lab Tests	90%	70%
Pre-Admission Testing	95%	70%

PROVISIONS	NETWORK ACCESS PLAN (NAP) ADMINISTERED BY ANTHEM BLUE CROSS	
	Network	***Non-Network***
Home Health Care	90%; requires prior authorization, $300 penalty if not obtained; excludes custodial care	70%; requires prior authorization, $300 penalty if not obtained; excludes custodial care
Hospice Care	90%; requires prior authorization, $300 penalty if not obtained; excludes custodial care	70%; requires prior authorization, $300 penalty if not obtained; excludes custodial care
Outpatient Physical Therapy	80%	70%
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health; see page 40 for details	Covered by separate drug plan administered by Medco Health; see page 40 for details
Mental Health	Covered by separate Mental Health Program:	Covered by separate Mental Health Program:
Inpatient Care	100% with referral by ValueOptions; 50% without referral	100% with referral by ValueOptions; 50% without referral
Outpatient Care	$15/visit with referral by ValueOptions, no charge for initial visit to psychiatrist (M.D.) for medication evaluation; 50% without referral, up to 30 visits per year	$15/visit with referral by ValueOptions, no charge for initial visit to psychiatrist (M.D.) for medication evaluation; 50% without referral, up to 30 visits per year
Inpatient and Outpatient Alcohol and Drug Care	Covered by separate alcohol and drug care program with referral by ValueOptions	Covered by separate alcohol and drug care program with referral by ValueOptions
Durable Medical Equipment	80%; preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained	70%; preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained
Chiropractic Care	80% for care approved by ASHN using ASHN provider	70% for up to 15 visits for Medically Necessary care
Acupuncture	80% for up to 20 visits per year from licensed acupuncturist or M.D.	70% for up to 15 visits per year from licensed acupuncturist or M.D.
Other Benefits	Infertility—Paid according to type of benefit; $7,000 lifetime maximum; balances from prior plans carry forward	Infertility—Paid according to type of benefit; $7,000 lifetime maximum; balances from prior plans carry forward

* *"Eligible Expenses" are: (1) expenses for Covered Health Services that are covered by the plan; (2) those that Anthem Blue Cross considers "Medically Necessary" for the diagnosis or treatment of an illness or injury; and (3) those that do not exceed the "Reasonable and Customary" rate as determined by Anthem Blue Cross. Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Anthem Blue Cross Member Services.*

Comparison Of Medical Benefits For Members Under 65

The information in this chart is intended as a high-level summary only. The information contained in an applicable service provider agreement between PG&E and Anthem Blue Cross shall govern in case of conflict between this chart and the service provider agreement.

PROVISIONS	COMPREHENSIVE ACCESS PLAN (CAP) ADMINISTERED BY ANTHEM BLUE CROSS	RETIREE OPTIONAL PLAN (ROP) ADMINISTERED BY ANTHEM BLUE CROSS
General	May use provider of choice or network providers; $100 annual deductible per individual, up to family maximum of $300; annual out-of-pocket maximum of $750 per individual, up to family maximum of $1,500 (includes deductible); no lifetime maximum; no pre-existing condition exclusions. All plan benefits and out-of-pocket maximums are based on Eligible Expenses only* All plan benefits and out-of-pocket maximums are based on Eligible Expenses only*	May use provider of choice; will experience savings if network doctor is used; $400 annual individual deductible; up to family maximum of $1,200; annual out-of-pocket maximum of $4,000 per individual (includes deductible); up to family maximum of $8,000; no lifetime maximum; no pre-existing condition exclusions
Hospital Stay	100% after $100 copay; preauthorization required for nonemergency care, $300 penalty if not obtained; covers semiprivate room (private if Medically Necessary); includes intensive care	70% after deductible; preauthorization required for nonemergency care, $250 penalty if not obtained; covers semiprivate room (private if Medically Necessary); includes intensive care
Skilled Nursing Facility	90% for semiprivate room after 3 days in hospital; preauthorization required, $300 penalty if not obtained; excludes custodial care	70% for semiprivate room after three days in hospital; excludes custodial care
Outpatient Hospital and Emergency Room Care	100% after $35 copay for medical emergency or outpatient surgery; waived if admitted	70% after deductible
Office Visits	Primary care—100% after $10 copay; Specialist (including OB/GYN)—100% after $20 copay	70% after deductible
Urgent Care Visits	Primary care—100% after $10 copay; Specialist (including OB/GYN)—100% after $20 copay	70% after deductible
Routine Physical Examinations	Primary care—100% after $10 copay; Specialist—100% after $20 copay; lab/X-ray covered separately	70% after deductible
Immunizations and Injections	95%	70% after deductible
Eye Examinations	Not covered	Not covered
X-rays and Lab Tests	90%	70% after deductible
Pre-Admission Testing	95%	70% after deductible

PROVISIONS	COMPREHENSIVE ACCESS PLAN (CAP) ADMINISTERED BY ANTHEM BLUE CROSS	RETIREE OPTIONAL PLAN (ROP) ADMINISTERED BY ANTHEM BLUE CROSS
Home Health Care	90%; requires prior authorization, $300 penalty if not obtained; excludes custodial care	70% after deductible; requires prior authorization; excludes custodial care
Hospice Care	90%; requires prior authorization, $300 penalty if not obtained; excludes custodial care	70% after deductible; requires prior authorization; excludes custodial care
Outpatient Physical Therapy	80%	70% after deductible
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health; see page 40 for details	Covered by separate drug plan administered by Medco Health; see page 40 for details
Mental Health	Covered by separate Mental Health Program:	Covered by separate Mental Health Program:
Inpatient Care	100% with referral by ValueOptions; 50% without referral	70% after deductible
Outpatient Care	$15/visit with referral by ValueOptions, no charge for initial visit to psychiatrist (M.D.) for medication evaluation; 50% without referral, up to 30 visits per year	70% after deductible
Inpatient and Outpatient Alcohol and Drug Care	Covered by separate alcohol and drug care program with referral by ValueOptions	70% after deductible
Durable Medical Equipment	80%; preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained	70% after deductible
Chiropractic Care	80% for Medically Necessary care only; preauthorization by ASHN required after initial visit	70% after deductible, 10-visit maximum per year
Acupuncture	80% for up to 20 visits per year from licensed acupuncturist or M.D.	70% after deductible
Other Benefits	Infertility—Paid according to type of benefit; $7,000 lifetime maximum; balances from prior plans carry forward	Infertility—70% after deductible, $7,000 lifetime maximum

* *"Eligible Expenses" are: (1) expenses for Covered Health Services that are covered by the plan; (2) those that Anthem Blue Cross considers "Medically Necessary" for the diagnosis or treatment of an illness or injury; and (3) those that do not exceed the "Reasonable and Customary" rate as determined by Anthem Blue Cross. Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Anthem Blue Cross Member Services.*

Comparison Of Medical Benefits For Members Under 65

The information in this chart is intended as a high-level summary only. The information about the HMOs or the insured products contained in an applicable Evidence of Coverage (EOC) or service provider agreement between PG&E and the HMO or service provider shall govern in case of conflict between this chart and the EOC or service provider agreement.

PROVISIONS	BLUE SHIELD HMO	HEALTH NET HMO
General	Members access the Blue Shield HMO network; no pre-existing condition exclusions	Only providers affiliated with Health Net HMO; no pre-existing condition exclusions
Hospital Stay	No charge	No charge; includes intensive and coronary care
Skilled Nursing Facility	No charge; 100-day limit	No charge; 100-day limit
Emergency Room Care	$25/visit for emergencies (waived if admitted); member needs to contact PCP within 24 hours of service	$25/visit for emergencies (waived if admitted); must notify Health Net within 48 hours
Outpatient Hospital Care	$10/visit	$10/visit
Office Visits	Office visit—$10; $30 without referral (Access+ Specialist)—must be in the same Medical Group or IPA; home visit—$10	Office visit—$10 Home visit—$10
Urgent Care Visits	$10/visit	$10/visit
Routine Physical Examinations	$10/visit according to health plan schedule	$10/visit for basic Periodic Health Evaluation
Immunizations and Injections	Included in office visit; no charge for allergy injections if no visit with physician	Included in office visit; no charge for allergy injections if no visit with physician
Eye Examinations	$10/visit for refraction	$10/visit
X-rays and Lab Tests	No charge	No charge
Pre-Admission Testing	No charge	No charge
Home Health Care	No charge	No charge
Hospice Care	No charge	No charge
Outpatient Physical Therapy	$10/visit; provided as long as continued treatment is medically necessary pursuant to the treatment plan	$10/visit; provided as long as significant improvement is expected
Outpatient Prescription Drugs	RETAIL (up to 30-day supply): $5 copay for generic formulary, $15 copay for brand formulary and $35 copay for nonformulary; some drugs require preauthorization; MAIL-ORDER (through the plan): two times retail copay for up to a 90-day supply; no annual maximum; open formulary	RETAIL (up to 30-day supply): $5 copay for generic formulary, $15 copay for brand formulary and $35 copay for nonformulary; some drugs require preauthorization; MAIL-ORDER (through the plan): two times retail copay for up to a 90-day supply; no annual maximum; open formulary

PROVISIONS	BLUE SHIELD HMO	HEALTH NET HMO
Mental Health*		
Inpatient Care	Severe mental illness (same as parity diagnosis): no charge; no day limit; other mental illnesses: no charge for up to 30 days/calendar year for crisis intervention	Severe mental illness (same as parity diagnosis): no charge; no day limit; other mental illnesses: no charge for up to 30 days/calendar year for crisis intervention
Outpatient Care	Severe mental illness (same as parity diagnosis): $10/visit; no visit limit; other mental illnesses: $20/visit; 20 visits per calendar year	Severe mental illness (same as parity diagnosis): $10/visit; no visit limit; other mental illnesses: $20/visit; 20 visits per calendar year
Inpatient and Outpatient Alcohol and Drug Care	Covered by separate alcohol and drug care program with referral by ValueOptions	Covered by separate alcohol and drug care program with referral by ValueOptions
Durable Medical Equipment	No charge; preauthorization required; see plan EOC for limitations and exclusions	No charge; see plan EOC for limitations and exclusions
Chiropractic Care/ Acupuncture	Discounts available; contact Member Services for details	Discounts available; contact Member Services for details

* *Coverage for mental health is provided through the HMO only, not ValueOptions*

Comparison Of Medical Benefits For Members Under 65

The information in this chart is intended as a high-level summary only. The information about the HMOs or the insured products contained in an applicable Evidence of Coverage (EOC) or service provider agreement between PG&E and the HMO or service provider shall govern in case of conflict between this chart and the EOC or service provider agreement.

PROVISIONS	KAISER PERMANENTE HMO NORTH AND SOUTH
General	Services provided at Kaiser Permanente hospitals and offices by Kaiser Permanente doctors; no pre-existing condition exclusions
Hospital Stay	No charge; includes intensive and coronary care
Skilled Nursing Facility	No charge to members in service area for up to 100 days per benefit period when prescribed by a plan physician; not covered for members living outside of service area
Emergency Room Care	$25/visit for emergencies (waived if admitted directly to the hospital within 24 hours for the same condition)
Outpatient Hospital	$10 per procedure for outpatient surgery; $10/visit for all other outpatient services may apply
Office Visits	Office visit—$10; Home visit—No charge
Urgent Care Visits	$10/visit
Routine Physical Examinations	$10/visit
Immunizations and Injections	$10/visit for immunizations and allergy testing if no office visit; $5/visit for allergy injections if no office visit
Eye Examinations	$10/visit for screening/refraction; lenses and frames not covered
X-rays and Lab Tests	No charge
Pre-Admission Testing	No charge
Home Health Care	No charge to members in service area when prescribed by a plan physician; not covered for members living outside of service area
Hospice Care	No charge to members in service area when prescribed by a plan physician; not covered for members living outside of service area
Outpatient Physical Therapy	$10/visit; therapy is given if in the judgment of a plan physician significant improvement is achievable
Outpatient Prescription Drugs	$10 copay for up to 100-day supply when obtained at a plan pharmacy or through the plan's mail-order; no annual maximum; closed formulary

PROVISIONS	KAISER PERMANENTE HMO NORTH AND SOUTH
Mental Health*	
Inpatient Care	No charge for up to 30 days per calendar year; no day limit for mental health parity diagnoses
Outpatient Care	$10/visit (individual), $5/visit (group) for up to 20 visits per calendar year; no visit limit for mental health parity diagnoses
Alcohol and Drug Care	
Inpatient Care	No charge for detoxification; also covered by separate alcohol and drug care program with referral by ValueOptions (inpatient only)
Outpatient Care	$10/visit (individual); $5/visit (group)
Durable Medical Equipment	No charge to members in service area when prescribed by a plan physician; see plan EOC for limitations and exclusions; not covered for members living outside of service area
Chiropractic Care/Acupuncture	Discounts available; contact Member Services for details

* *Coverage for mental health is provided through the HMO only, not ValueOptions*

Comparison Of Medical Benefits For Medicare-Eligible Members

The information in this chart is intended as a high-level summary only. The information contained in an applicable service provider agreement between PG&E and Anthem Blue Cross shall govern in case of conflict between this chart and the service provider agreement.

PROVISIONS	COMPREHENSIVE ACCESS PLAN (CAP) ADMINISTERED BY ANTHEM BLUE CROSS	PG&E MEDICARE SUPPLEMENTAL PLAN (MSP) ADMINISTERED BY ANTHEM BLUE CROSS
General	May use provider of choice or network providers; $100 annual deductible per individual, up to family maximum of $300; annual out-of-pocket maximum of $750 per individual, up to family maximum of $1,500 (includes deductible); no lifetime maximum; no pre-existing condition exclusions All plan benefits and out-of-pocket maximums are based on Eligible Expenses only*	Available to all retirees and eligible dependents who have Medicare (if retiree elects Medicare Supplemental Plan and spouse does not have Medicare, spouse will be enrolled in appropriate Anthem Blue Cross-administered medical plan); worldwide coverage; $100 annual individual deductible; $10,000 lifetime maximum on benefits (up to $1,000 restored each year); no pre-existing condition exclusions All plan benefits and out-of-pocket maximums are based on Eligible Expenses only*
Hospital Stay	100% after a $100 copayment; preauthorization required for nonemergency care, $300 penalty if not obtained; covers semiprivate room (private if Medically Necessary); includes intensive care	After deductible, 80% of eligible hospital expenses not covered by Medicare
Skilled Nursing Facility	90% for semiprivate room after three days in hospital; preauthorization required, $300 penalty if not obtained; excludes custodial care	After deductible, 80% of member copay amount per Medicare from 21st to 100th day of confinement; excludes custodial care
Outpatient Hospital and Emergency Room Care	100% after $35 copay for medical emergency or outpatient surgery; waived if admitted	After deductible, 80% of eligible expenses not covered by Medicare
Office Visits	Primary care—100% after $10 copay; specialist (including OB/GYN)—100% after $20 copay	After deductible, 80% of eligible expenses not covered by Medicare
Urgent Care Visits	Primary care—100% after $10 copay; specialist (including OB/GYN)—100% after $20 copay	After deductible, 80% of eligible expenses not covered by Medicare
Routine Physical Examinations	Primary care—100% after $10 copay; specialist—100% after $20 copay; lab/X-ray covered separately	Not covered
Immunizations and Injections	95%	Not covered
Eye Examinations	Not covered	Not covered
X-rays and Lab Tests	90%	After deductible, 80% of eligible expenses not covered by Medicare

PROVISIONS	COMPREHENSIVE ACCESS PLAN (CAP) ADMINISTERED BY ANTHEM BLUE CROSS	PG&E MEDICARE SUPPLEMENTAL PLAN (MSP) ADMINISTERED BY ANTHEM BLUE CROSS
Pre-Admission Testing	95%	After deductible, 80% of eligible expenses not covered by Medicare
Home Health Care	90%; requires prior authorization; $300 penalty if not obtained; excludes custodial care	After deductible, 80% of eligible expenses not covered by Medicare; excludes custodial care
Hospice Care	90%; requires prior authorization; $300 penalty if not obtained; excludes custodial care	After deductible, 80% of eligible expenses not covered by Medicare; excludes custodial care
Outpatient Physical Therapy	80%	After deductible, 80% of eligible expenses not covered by Medicare
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health; see page 40 for details	Covered by separate drug plan administered by Medco Health; see page 40 for details
Mental Health	Covered by separate Mental Health Program:	
Inpatient Care	100% with referral by ValueOptions; 50% without referral	After deductible, 80% of eligible expenses not covered by Medicare
Outpatient Care	$15/visit with referral by ValueOptions, no charge for initial visit to psychiatrist (M.D.) for medication evaluation; 50% without referral, up to 30 visits per year	Not covered
Inpatient and Outpatient Alcohol and Drug Care	Covered by separate alcohol and drug care program with referral by ValueOptions	Not covered
Durable Medical Equipment	80%; preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained	After deductible, 80% of eligible expenses not covered by Medicare
Chiropractic Care	80% for Medically Necessary care only; preauthorization by ASHN required after initial visit	After deductible, 80% of eligible expenses not covered by Medicare; services must be Medically Necessary
Acupuncture	80% for up to 20 visits per year from licensed acupuncturist or M.D.	Not covered
Other Benefits	Infertility—Paid according to type of benefit; $7,000 lifetime maximum; balances from prior plans carry forward	

* *"Eligible Expenses" are: (1) expenses for Covered Health Services that are covered by the plan; (2) those that Anthem Blue Cross considers "Medically Necessary" for the diagnosis or treatment of an illness or injury; and (3) those that do not exceed the "Reasonable and Customary" rate as determined by Anthem Blue Cross. Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Anthem Blue Cross Member Services.*

Comparison Of Medical Benefits For Medicare-Eligible Members

The information in this chart is intended as a high-level summary only. The information about the HMOs or the insured products contained in an applicable Evidence of Coverage (EOC) or service provider agreement between PG&E and Anthem Blue Cross shall govern in case of conflict between this chart and the EOC or service provider agreement.

PROVISIONS	RETIREE OPTIONAL PLAN (ROP) ADMINISTERED BY ANTHEM BLUE CROSS	ANTHEM BLUE CROSS OF CALIFORNIA SMARTVALUE MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE (PFFS) PLAN
General	May use provider of choice; will experience savings if network doctor is used; $400 annual individual deductible; up to family maximum of $1,200; annual out-of-pocket maximum of $4,000 per individual (includes deductible), up to family maximum of $8,000; no lifetime maximum; no pre-existing condition exclusions All plan benefits and out-of-pocket maximums are based on Eligible Expenses only*	Only providers who have agreed to accept the terms of the SmartValue plan; no pre-existing condition exclusions
Hospital Stay	70% after deductible; preauthorization required for nonemergency care, $250 penalty if not obtained; covers semiprivate room (private if Medically Necessary); includes intensive care	No charge for semiprivate room (private if Medically Necessary); includes intensive and coronary care; unlimited days
Skilled Nursing Facility	70% for semiprivate room after three days in hospital; excludes custodial care	No charge; 100 days per benefit period
Outpatient Hospital (Nonemergency)	70% after deductible	$10 copay
Emergency Room Care	70% after deductible	$25 copay (waived if admitted within 72 hours)
Office Visits	70% after deductible	$10 copay/visit for primary care physician or specialist
Urgent Care Visits	70% after deductible	$10 copay/visit
Routine Physical Examinations	70% after deductible	$10 copay/visit
Immunizations and Injections	70% after deductible	Flu, pneumonia and Hepatitis B: No charge except for 20% coinsurance for foreign travel and/or occupational reasons
Eye Examinations	Not covered	$10 copay for physician eye care services and for routine eye exams
X-rays and Lab Tests	70% after deductible	No charge

PROVISIONS	RETIREE OPTIONAL PLAN (ROP) ADMINISTERED BY ANTHEM BLUE CROSS	ANTHEM BLUE CROSS OF CALIFORNIA SMARTVALUE MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE (PFFS) PLAN
Pre-Admission Testing	70% after deductible	No charge
Hospice and Home Health Care	70% after deductible; requires prior authorization; excludes custodial care	Home Health: No charge if Medically Necessary; Hospice: No charge; must use a Medicare-certified hospice
Outpatient Physical Therapy	70% after deductible	No charge
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health; see page 40 for details	Medicare Part D plan: RETAIL (up to 30-day supply): $5 copay for generic formulary, $15 copay for brand formulary and $35 for nonformulary; MAIL-ORDER (through the plan, up to 90-day supply): $10 copay for generic formulary, $30 copay for brand formulary and $70 for nonformulary
Mental Health		
Inpatient Care	70% after deductible	No charge for up to 190 days per lifetime
Outpatient Care	70% after deductible	$20 copay/visit
Alcohol and Drug Care		
Inpatient Care	70% after deductible	No charge
Outpatient Care	70% after deductible	$20 copay/visit
Durable Medical Equipment	70% after deductible	$100 copay for equipment over $750; if you pre-notify by calling Customer Service, the copay is waived
Chiropractic Care	70% after deductible, 10-visit maximum per year	$10 copay/visit (limited to manual manipulation per Medicare guidelines)
Acupuncture	70% after deductible	Not covered
Other Benefits	Infertility—70% after deductible, $7,000 lifetime maximum; hearing aids—70% up to $2,800 annually	

* *"Eligible Expenses" are: (1) expenses for Covered Health Services that are covered by the plan; (2) those that Anthem Blue Cross considers "Medically Necessary" for the diagnosis or treatment of an illness or injury; and (3) those that do not exceed the "Reasonable and Customary" rate as determined by Anthem Blue Cross. Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Anthem Blue Cross Member Services.*

Comparison Of Medical Benefits For Medicare-Eligible Members

The information in this chart is intended as a high-level summary only. The information about the HMOs or the insured products contained in an applicable Evidence of Coverage (EOC) or service provider agreement between PG&E and the HMO or service provider shall govern in case of conflict between this chart and the EOC or service provider agreement.

PROVISIONS	BLUE SHIELD MEDICARE COB HMO
General	Members access the Blue Shield HMO network; no pre-existing condition exclusions
Hospital Stay	No charge
Skilled Nursing Facility	No charge, 100-day limit
Emergency Room Care	$25/visit for emergencies (waived if admitted); member must contact PCP within 24 hours of service
Outpatient Hospital Care	$10/visit
Office Visits	Office visit—$10; $30 without referral (Access+ Specialist)—must be in the same Medical Group or IPA Home visit—$10
Urgent Care Visits	$10/visit
Routine Physical Examinations	$10/visit according to health plan schedule
Immunizations and Injections	Included in office visit; no charge for allergy injections if no visit with physician
Eye Examinations	$10/visit for refraction
X-rays and Lab Tests	No charge
Pre-Admission Testing	No charge
Home Health Care	No charge
Hospice Care	No charge
Outpatient Physical Therapy	$10/visit; as long as continued treatment is medically necessary pursuant to the treatment plan
Outpatient Prescription Drugs	Medicare Part D plan—see Medicare Part D booklet for more information: RETAIL (up to 30-day supply): $5 copay for generic formulary, $15 copay for brand formulary and $35 for nonformulary; some drugs require preauthorization; MAIL-ORDER (through the plan): two times retail copay for up to a 90-day supply; no annual maximum; open formulary

PROVISIONS	BLUE SHIELD MEDICARE COB HMO
Mental Health*	
Inpatient Care	Severe mental illnesses (same as parity diagnosis): no charge, no day limit; other mental illnesses: no charge for up to 30 days per calendar year for crisis intervention
Outpatient Care	Severe mental illnesses (same as parity diagnosis): $10/visit, no visit limit; other mental illnesses: $20/visit, 20 visits per calendar year
Alcohol and Drug Care	
Inpatient Care	Covered by separate alcohol and drug care program with referral by ValueOptions
Outpatient Care	Covered by separate alcohol and drug care program with referral by ValueOptions
Durable Medical Equipment	No charge; preauthorization required; see plan EOC for limitations and exclusions
Chiropractic Care/Acupuncture	Discounts available; contact Member Services for details

* *Coverage for mental health is provided through the HMO only, not ValueOptions*

Comparison Of Medical Benefits For Medicare-Eligible Members

The information in this chart is intended as a high-level summary only. The information about the HMOs or the insured products contained in an applicable Evidence of Coverage (EOC) or service provider agreement between PG&E and the HMO or service provider shall govern in case of conflict between this chart and the EOC or service provider agreement.

PROVISIONS	HEALTH NET MEDICARE COB HMO	HEALTH NET SENIORITY PLUS (MEDICARE ADVANTAGE HMO)
General	Only providers affiliated with Health Net HMO; no pre-existing condition exclusions	Only providers affiliated with Health Net HMO; no pre-existing condition exclusions
Hospital Stay	No charge; includes intensive and coronary care	No charge; includes intensive and coronary care
Skilled Nursing Facility	No charge; 100-day limit	No charge, 100-day limit per benefit period; no prior hospital stay required
Emergency Room Care	$25/visit for emergencies (waived if admitted); must notify Health Net within 48 hours	$25/visit for emergencies (waived if admitted); must notify Health Net within 48 hours
Outpatient Hospital Care	$10/visit	$10/visit
Office Visits	Office visit – $10	Office visit—$10 Home visit—$10
Urgent Care Visits	$10/visit	$10/visit
Routine Physical Examinations	$10/visit for basic periodic health evaluation	$10/visit
Immunizations and Injections	Included in office visit; no charge for allergy injections if no visit with physician	Included in office visit; exceptions: 20% copay for immunizations for foreign travel/ occupational reasons
Eye Examinations	$10/visit	$10/visit
X-rays and Lab Tests	No charge	No charge
Pre-Admission Testing	No charge	No charge
Home Health Care	No charge	No charge
Hospice Care	No charge	No charge
Outpatient Physical Therapy	$10/visit (provided as long as significant improvement is expected)	No charge
Outpatient Prescription Drugs	Medicare Part D plan—see Medicare Part D booklet for more information; RETAIL (up to 30-day supply) $5 copay for generic formulary, $15 copay for brand formulary and $35 for nonformulary; some drugs require preauthorization; MAIL-ORDER (through the plan): two times retail copay for up to a 90-day supply; no annual maximum; open formulary	Medicare Part D plan—see Medicare Part D booklet for more information; RETAIL (up to 30-day supply) $5 copay for generic formulary, $15 copay for brand formulary and $35 for nonformulary; some drugs require preauthorization; MAIL-ORDER (through the plan): two times retail copay for up to a 90-day supply; no annual maximum; open formulary

PROVISIONS	HEALTH NET MEDICARE COB HMO	HEALTH NET SENIORITY PLUS (MEDICARE ADVANTAGE HMO)
Mental Health*		
Inpatient Care	Severe mental illnesses (same as parity diagnoses): no charge; no day limit; other mental illnesses: no charge for up to 30 days per calendar year for crisis intervention	No charge; 190 days per lifetime
Outpatient Care	Severe mental illnesses (same as parity diagnoses): $10/visit; no visit limit; other mental illnesses: $20/visit; 20 visits per calendar year	$20/visit; no maximum
Alcohol and Drug Care		
Inpatient Care	Covered by separate alcohol and drug care program with referral by ValueOptions	No charge; also covered by separate alcohol and drug care program with referral by ValueOptions
Outpatient Care	Covered by separate alcohol and drug care program with referral by ValueOptions	$20/visit; no maximum; also covered by separate alcohol and drug care program with referral by ValueOptions
Durable Medical Equipment	No charge; see plan EOC for limitations and exclusions	No charge; see plan EOC for limitations and exclusions
Chiropractic Care	Discounts available; contact Member Services for details	$10/visit for Medicare-approved chiropractic services
Acupuncture	Discounts available; contact Member Services for details	Discounts available; contact Member Services for details

* *Coverage for mental health is provided through the HMO or SmartValue only, not ValueOptions*

Comparison Of Medical Benefits For Medicare-Eligible Members

The information in this chart is intended as a high-level summary only. The information about the HMOs or the insured products contained in an applicable Evidence of Coverage (EOC) or service provider agreement between PG&E and the HMO or service provider shall govern in case of conflict between this chart and the EOC or service provider agreement.

PROVISIONS	KAISER PERMANENTE SENIOR ADVANTAGE NORTH AND SOUTH (MEDICARE HMO)
General	Services provided at Kaiser Permanente hospitals and offices by Kaiser Permanente doctors; no pre-existing condition exclusions
Hospital Stay	No charge; includes intensive and coronary care
Skilled Nursing Facility	No charge to members in service area for up to 100 days per benefit period when prescribed by a plan physician; no prior hospital stay required; not covered for members living outside of service area
Emergency Room Care	$25/visit for emergencies (waived if admitted directly to the hospital within 24 hours for the same condition)
Outpatient Hospital Care	$10 per procedure for outpatient surgery; $10/visit for all other outpatient services may apply
Office Visits	Office visit—$10
Urgent Care Visits	$10/visit at a Kaiser facility in area; $25/visit at non-Kaiser facility
Routine Physical Examinations	$10/visit
Immunizations and Injections	$10 for immunizations and allergy testing if no office visit; $3/visit for allergy injections if no office visit
Eye Examinations	$10/exam; $150 eyewear allowance including medically necessary eyewear every 24 months
X-rays and Lab Tests	No charge
Pre-Admission Testing	No charge
Home Health Care	No charge to members in service area when prescribed by a plan physician; not covered for members living outside of service area
Hospice Care	Covered under Medicare for members with Medicare Parts A and B when prescribed by a plan physician; no charge to Medicare Part B-only members in service area when prescribed by a plan physician; not covered for Medicare Part B-only members living outside of service area
Outpatient Physical Therapy	$10/visit; provided as long as, in the judgment of a plan physician, significant improvement is achievable
Outpatient Prescription Drugs	Medicare Part D plan—see Medicare Part D booklet for more information: $10 per prescription for up to 100-day supply when obtained at a plan pharmacy or through the plan's mail-order; no annual maximum; closed formulary

PROVISIONS	KAISER PERMANENTE SENIOR ADVANTAGE NORTH AND SOUTH (MEDICARE HMO)
Mental Health*	
Inpatient Care	No charge; 190 days lifetime; no charge for up to 45 additional days per calendar year after 190-day limit is reached; no day limit for mental health parity diagnoses
Outpatient Care	$10/visit (individual); $5/visit (group); no visit limit for mental health parity diagnoses
Alcohol and Drug Care	
Inpatient Care	No charge for detoxification; also covered by separate alcohol and drug care program with referral by ValueOptions (inpatient only)
Outpatient Care	$10/visit (individual); $5/visit (group)
Durable Medical Equipment	No charge to members in service area when prescribed by a plan physician; not covered for members living outside of service area; see plan EOC for limitations and exclusions
Chiropractic Care	Discounts available; contact Member Services for details
Acupuncture	Discounts available; contact Member Services for details

* *Coverage for mental health is provided through the HMO or SmartValue only, not ValueOptions*

Prescription Drug Benefits

The information in this table is intended as a high-level summary only. This table summarizes the prescription drug benefits for members enrolled in the Anthem Blue Cross-administered plans, except the SmartValue Plan. Plan benefits are administered by Medco Health. Please note that the Medco Health out-of-pocket maximum must be met separately from the Anthem Blue Cross out-of-pocket maximum. Also, some drugs may not be covered or may require special authorization from Medco Health. For specific information about prescription drug coverage, call Medco Health's Member Services department directly, or visit its Web site at *www.medcohealth.com*.

For general information regarding the prescription drug coverage provided by each HMO, refer to Outpatient Prescription Drugs on the Comparison of Medical Benefits charts on pages 26 to 29 and 34 to 39. For more specific information about an HMO's drug coverage, call the HMO's Member Services department directly, or visit its Web site at the Internet address listed on the inside back cover of this guide.

PROVISIONS	NAP, CAP AND BASIC PLANS	PG&E MEDICARE SUPPLEMENTAL PLAN (MSP) MEMBERS	RETIREE OPTIONAL PLAN (ROP) MEMBERS
Retail Drug Purchases	First three 30-day supplies at a participating pharmacy: 85% for generics, 75% for brand names. Refills beyond 90 days and coverage at nonparticipating pharmacies: 80% for generics, 70% for brand names. Generic Incentive Provision applies (see below)	75% after deductible; Generic Incentive Provision applies (see below)	60% after deductible at any retail pharmacy
Mail-Order Purchases	90% for generic drugs and 80% for brand-name drugs; Generic Incentive Provision applies (see below)	80% after deductible; Generic Incentive Provision applies (see below)	70% after deductible for 90-day supply
Generic Incentive Provision	Member is responsible for paying the difference between the price of a generic drug and a brand-name drug, plus coinsurance, if purchasing a brand-name drug when a generic version is available; please note that any generic-brand price differential you pay is a noncovered expense and, thus, does not count toward your annual out-of-pocket maximum (see below); drugs that are listed on Medco Health's "Narrow Therapeutic List" will be excluded from this mandatory generic provision		Not applicable
Deductible	No deductible	$100 per person (separate from medical plan deductible); retail and mail-order deductible is combined	$200 per person; no family maximum; retail and mail-order deductible is combined

PROVISIONS	NAP, CAP AND BASIC PLANS	PG&E MEDICARE SUPPLEMENTAL PLAN (MSP) MEMBERS	RETIREE OPTIONAL PLAN (ROP) MEMBERS
Annual Out-of-Pocket Maximum	$500 per person up to a family maximum of $1,000; out-of-pocket maximum coordinates the retail drug plan with the mail-order drug plan, but does not coordinate with the medical plan; noncovered expenses, such as generic-brand price differentials, are not eligible expenses and, thus, will not be covered by the plan after your annual out-of-pocket maximum is met	None	$1,500 per person up to a family maximum of $3,000; out-of-pocket maximum coordinates the retail drug plan with the mail-order drug plan, but does not coordinate with medical plan
Lifetime Maximum	No lifetime maximum	$10,000 per person, with up to $1,000 restored annually (does not apply to drugs purchased before 2004); separate from medical plan lifetime maximum	No lifetime maximum
Infertility, Sexual Dysfunction, Memory Enhancement and Contraceptive Drugs	50% for both retail and mail-order plan, unless medically necessary. Medically necessary drugs are covered at standard reimbursement rates; Generic Incentive Provision applies (see above)	Covered only to treat serious medical conditions; Generic Incentive Provision applies (see above)	50% after deductible

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

NOTES:

YOUR AUTHORIZATION—PLEASE READ

By participating in any of the benefit plans sponsored by Pacific Gas and Electric Company, you:

- Acknowledge that you are responsible for reading the 2009 enrollment material, including your Enrollment Worksheet, this 2009 Benefits Enrollment Guide, the Supplement to Your 2009 Benefits Enrollment Guide and your confirmation statement;
- Acknowledge that you have received the Notice about Your Prescription Drug Coverage and Medicare included in the Supplement to Your 2009 Benefits Enrollment Guide;
- Acknowledge that you understand your PG&E medical and prescription drug coverage will be canceled if you enroll in a Medicare Part D Prescription Drug Plan or Medicare Advantage plan outside of the PG&E enrollment process;
- Authorize Pacific Gas and Electric Company, PG&E Corporation and their affiliates ("Participating Employers") to release Social Security numbers for you and your dependents to third-party administrators and insurers, as required, for purposes of plan administration;
- Authorize Participating Employers to deduct any required contributions from your pension check, if applicable, or to bill you if your pension check is not sufficient;
- Acknowledge that you may not be able to change medical plans during 2009;
- Acknowledge that you will not be able to change medical plans during 2009 if your desired physician, hospital, medical group or Independent Physician Association (IPA) does not participate in or terminates its relationship with your medical plan's network;
- Acknowledge that you will not be able to change medical plans during 2009 if your Retiree Premium Offset Account (RPOA) balance becomes depleted;
- Acknowledge that PG&E, the other Participating Employers, the health plan administrators and the insurers do not provide medical services or make treatment decisions; all treatment decisions are between you and your physician, regardless of the benefits covered under the plan;
- Agree to follow the appeal process for your plan for any disputed benefit claims;
- Agree to call the HR Service Center to report any ineligible dependents within 31 days of a dependent's loss of eligibility.

PG&E BENEFITS INFORMATION AND REFERENCES

PG&E HR Service Center	E-mail: *hrbenefitsquestions@exchange.pge.com* Phone: 415-972-7077 or 1-800-700-0057
***PG&E@Work For Me* on the Internet**	*https://myportal.pge.com*
PG&E's Summary of Benefits Handbook	Available in paper form or on CD-Rom. Call the HR Service Center to request a copy free of charge.
IRS Publications	*www.irs.gov*
Social Security Administration	1-800-772-1213

SUMMARY OF MATERIAL MODIFICATIONS (OCTOBER 2008)

The 2009 Benefits Enrollment Guide and Supplement constitute a Summary of Material Modifications to the PG&E Health Care Plan.

Pacific Gas and Electric Company has the right to amend or terminate the Health Care Plan at any time and for any reason, subject to notice provisions if such notice is required under applicable collective bargaining agreements. Generally, an amendment to or termination of the Health Care Plan will apply prospectively and will affect your rights and obligations under the Health Care Plan prospectively.

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MEMBER SERVICES CONTACTS

Plan	Phone No.	Web Site	Group No.
Blue Shield HMO and Medicare COB HMO	1-800-443-5005	www.blueshieldca.com/pge	H11473
Health Net HMO and Medicare COB HMO	1-800-522-0088	www.healthnet.com/pge	68992M
Health Net Seniority Plus	Current members: 1-800-275-4737 Prospective members: 1-800-596-6565	www.healthnet.com/pge	68992S
Kaiser Permanente (North and South)	1-800-464-4000	www.my.kaiserpermanente.org/ca/pge	North: 738-0001 South: 107932-0002
Kaiser Permanente Senior Advantage (North and South)	1-800-443-0815	www.my.kaiserpermanente.org/ca/pge	North: 738-0001 South: 107932-0002
PacifiCare HMO*	1-800-624-8822	www.pacificare.com	141347
PacifiCare Secure Horizons*	1-800-228-2144	www.securehorizons.com	141351
PG&E Medical Plans (Administered by Anthem Blue Cross) Network Access Plan (NAP) Comprehensive Access Plan (CAP) Retiree Optional Plan (ROP) American Specialty Health Network (ASHN)	1-800-964-0530 1-800-678-9133	www.anthem.com/ca/pge or www.ashplans.com	PZG170157
SmartValue	Pre-enrollment: 1-866-657-4970 Post-enrollment: 1-877-326-2201	www.anthem.com/ca/pge	XDV170157
Mental Health, Alcohol and Drug Care Program (Administered by ValueOptions)	1-800-562-3588	www.valueoptions.com	
Prescription Drug Plan (Administered by Medco Health)	1-800-718-6590	www.medcohealth.com	PGE0000
COBRA (Administered by Ceridian)	1-800-877-7994	www.ceridian-benefits.com	

* *Discontinued for all members effective January 1, 2009. See page 2 for more detail.*