What's New For 2004

Medical Plan

Summary of Material Modifications for PG&E Retirees and Surviving Dependents

Introduction

This booklet describes important changes to your PG&E medical plan coverage that will become effective on January 1, 2004. This document is being provided to you as a supplement to the Open Enrollment materials that will be sent to you in about a month and as an update, or "Summary of Material Modifications," to your Summary of Benefits Handbook. By providing you with detailed information about these changes early, it is our hope that you will have ample time to become familiar with the various changes and will be prepared to make well-informed benefit decisions when you receive your Open Enrollment materials. Please keep this information for future reference.

Open Enrollment For 2004

This year's Open Enrollment period is October 13 through October 24, 2003. You will receive enrollment instructions prior to the Open Enrollment period, along with information on which medical plans are available in your area.

The changes in the medical plans offered are significant. It's a good idea to think about which plan is best for you and your dependents now. Then, if you want to make changes, you'll be given the opportunity to do so during Open Enrollment. Questions on the information in this brochure can be directed to the PG&E HR Service Center. The telephone number is 1-800-700-0057, or send your questions by e-mail to HRBenefitsQuestions@pge.com. You may also call the medical plans directly. A list of telephone numbers and websites is provided at the end of this brochure.

What's New for 2004

There will be many changes to the medical plans in 2004. PG&E is making these changes for a couple of reasons. First, the changes make the plans easier to use and more up-to-date with what other employers are offering. Second, the changes help to lower PG&E's costs for retiree medical coverage while still offering medical plans with coverage that is affordable to you. So

while you will see some costs going up, like copayments, you will see other changes that will help you manage costs, such as the new Retiree Premium Offset Account that eligible retirees can use to reduce their medical premiums. The chart below summarizes the changes. The remainder of this booklet will discuss the changes in more detail.

CURRENT PLAN	***WHAT'S NEW FOR 2004***
UnitedHealthcare Point of Service (POS) Plan	• Replaced by UnitedHealthcare Network Access Plan (NAP) • Same network of hospitals and doctors
UnitedHealthcare Preferred Provider Organization (PPO) Plan	• Replaced by UnitedHealthcare Network Access Plan (NAP) • Same network of hospitals and doctors
UnitedHealthcare Out-Of-Area (OOA) Plan	• Replaced by UnitedHealthcare Comprehensive Access Plan (CAP)
UnitedHealthcare Retiree Optional Plan (ROP)	• Decrease in annual deductible from $500 to $400 per person and from $1,500 to $1,200 per family • Decrease in annual individual out-of-pocket maximum from $5,000 to $4,000, and in family maximum from $10,000 to $8,000
PG&E Medicare Supplemental Plan (MSP) – Administered by UnitedHealthcare	• Retirees who were **not** in a bargaining unit and who are age 65 or over are now eligible to elect this plan • Improved coverage for prescription drugs • Increase in lifetime maximum from $7,500 to $10,000 for medical expenses • New separate lifetime maximum of $10,000 for prescription drugs
All UnitedHealthcare Plans	• New Cancer Resource Services (CRS) program
Health Maintenance Organizations (HMOs) • Health Net • Kaiser • PacifiCare	• Office copayments increasing from $5 to $10 • Some other copayments also changing (e.g., emergency room, mental health visits, prescription drugs – will vary by HMO) • Aetna HMO will no longer be offered
Prescription Drug Plan (for UnitedHealthcare members)	• Will provide additional incentives for using generic drugs and home delivery • MSP drug benefits improved
Mental Health, Alcohol and Drug Care Benefits	• Copayments for outpatient visits changing
Retiree Premium Offset Account	• New program to help eligible retirees pay Company medical plan premiums!

Plans Administered by UnitedHealthcare

In 2004, the medical plans administered by UnitedHealthcare will be:

UNITEDHEALTHCARE PLAN:	AVAILABLE TO:
Network Access Plan (NAP)	• Retirees and dependents who are not eligible for Medicare, and who meet access standards
Comprehensive Access Plan (CAP)	• Retirees and dependents who are not eligible for Medicare, and who don't meet the NAP access standards • Retirees and dependents who are eligible for Medicare
Retiree Optional Plan (ROP)	• All retirees and dependents
Medicare Supplemental Plan (MSP)	• All retirees and dependents who are over age 65 and eligible for Medicare

Two New UnitedHealthcare Plans Replacing POS, PPO and Out-Of-Area Plans

The Point of Service (POS) Plan, the Preferred Provider Organization (PPO) Plan, and the Out-of-Area (OOA) Plan, all administered by UnitedHealthcare, are being replaced with two newly-designed plans – the Network Access Plan (NAP) and the Comprehensive Access Plan (CAP) – that reflect current practices in the health plan market place. A summary of benefits for each of the new plans can be found on the charts provided at the end of this section. These benefit summaries will also be included with your Open Enrollment materials.

As a rule of thumb, in most areas where the Point Of Service (POS) Plan and the Preferred Provider Organization (PPO) Plan are currently offered, the Network Access Plan (NAP) will be the new UnitedHealthcare plan offered.

Likewise, in most areas where the Out-Of-Area Plan is currently offered, the Comprehensive Access Plan (CAP) will most likely be the new plan offered. Your Open Enrollment materials will identify the medical plans available to you.

How the Plans Work

Network Access Plan (NAP). The Network Access Plan (NAP) is considered a preferred provider organization (PPO). However, this new plan has a different design than PG&E's current PPO Plan and is only available to members who are not eligible for Medicare.

One of the advantages of the Network Access Plan (NAP) is that the plan allows members to see specialists directly, without first seeking authorization from a primary care physician. The NAP Plan encourages the use of a nationwide network of providers by providing a higher level of reimbursement when members use network providers. NAP members still have the option of using a non-network provider, but will receive a reduced level of reimbursement when they do so.

Comprehensive Access Plan (CAP). Comprehensive Access Plan members receive the same level of benefits that NAP members receive, except that their level of benefit reimbursement will not be reduced if they use non-network providers. However, as an added incentive to use network providers, CAP members who are not Medicare participants will receive network discounts when they do use network providers. In addition, network providers cannot bill CAP members any costs over and above their established payment schedule with UnitedHealthcare. CAP members will also have the same types of preventive services, (e.g., routine physical examinations) as members of the NAP Plan.

Same Networks As In 2003

The NAP Plan will use the same network of hospitals, doctors and other health care professionals that is currently being used by both the Point of Service and Preferred Provider Organization Plans. This means that existing POS or PPO Plan members will not have to change doctors. However, this does not mean that changes to the network's providers will not occur. UnitedHealthcare reviews its network needs on an ongoing basis, and doctors and hospitals also review their contracts with medical plans. If UnitedHealthcare and your providers do not renew their existing agreements, your providers may drop out of the network.

Eligibility

UnitedHealthcare will use its standard criteria for determining who will be eligible to enroll in the Network Access Plan (NAP). Members who meet the following access criteria will be eligible to join the NAP Plan. Members who do not meet these criteria or who are eligible for Medicare will be eligible to enroll in the Comprehensive Access Plan (CAP).

AREA	NETWORK ACCESS PLAN (NAP) ACCESS STANDARDS
Urban	• One hospital within 10 miles • Two primary care physicians within 8 miles • Two OB/GYNs within 8 miles • Two pediatricians within 8 miles
Suburban	• One hospital within 15 miles • Two primary care physicians within 15 miles • Two OB/GYNs within 15 miles • Two pediatricians within 15 miles
Rural	• One hospital within 30 miles • Two primary care physicians within 30 miles • Two OB/GYNs within 30 miles • Two pediatricians within 30 miles

Use of Primary Care Physicians

PG&E continues its commitment toward coordination of medical care. When the concept of managed care was first introduced in the early 1990s, the practice of using primary care physicians as a coordinator of care became common.

Primary care physicians are internists, family practitioners, general practitioners or pediatricians. UnitedHealthcare does not consider an OB/GYN to be a primary care physician.

The Network Access Plan (NAP) will not require you to select a primary care physician. Nor will you need to get a referral from a primary care physician in order to see a specialist. Nevertheless, you may want to continue or establish a relationship with a primary care physician who can coordinate your overall medical care.

The NAP Plan has a lower copayment of $10 for visits to primary care physicians than the $20 copayment for visits to specialists, but allows you to see specialists without a referral. This newer approach to coordinated care, which is being embraced by many employers, allows direct access to specialists.

Referrals to Specialists

None of the medical plans administered by UnitedHealthcare will require a referral to see a specialist.

Basic/Major Terms No Longer Apply

Two of the current plans, the Preferred Provider Organization Plan and the Out-Of-Area Plan, have benefit designs called Basic/Major benefits. However, the practice of differentiating between Basic/Major benefits is outdated and, thus, not typically used by modern-day health plans. The new, simpler design, which does not differentiate between Basic and Major benefits, will be easier to use.

Example:

COVERED SERVICE	2003 PPO PLAN	2004 NAP and CAP PLANS
X-RAY AND LAB TESTS	• Basic pays 100% of the first $200 each calendar year • Major pays 80% after deductible thereafter	Plan pays 90%

Deductibles in 2004

There will be no deductibles in 2004 for NAP members who use network providers or for CAP members. NAP members who don't use network providers will have a deductible of $200 per person and $600 per family.

Deductibles Effective 2005

Effective January 1, 2005, the annual deductible will be $100 per person with a $300 family maximum for Network Access Plan (NAP) members who use network providers and for Comprehensive Access Plan (CAP) members. NAP members who don't use network providers will continue to have a deductible of $200 per person and $600 per family.

Annual Out-Of-Pocket Maximums

An out-of-pocket maximum is the maximum amount you pay each calendar year for covered expenses. For Network Access Plan (NAP) members who use network providers and for Comprehensive Access Plan (CAP) members, the annual out-of-pocket maximum is $750 per person with a family maximum of $1,500. NAP members who don't use network providers will have an annual out-of-pocket maximum of $1,000 per person with a $2,000 family maximum.

Charges for non-covered services, charges above Reasonable and Customary Charges, and penalties for non-notification do not apply toward the annual out-of-pocket maximum.

Chiropractic Care

Pre-approval is necessary for members of the Network Access Plan (NAP), and for members of the Comprehensive Access Plan (CAP) after the initial visit to a chiropractor. Chiropractic care will be reimbursed at 80% when visits are to a network provider and the care is approved by American Specialty Health Network (ASHN).

If NAP members do not obtain approval from American Specialty Health Network, benefits will be reimbursed at 70% for up to 15 visits for Medically Necessary care. CAP members will only have the initial visit reimbursed at 80% if subsequent visits are not approved.

You obtain approval from American Specialty Health Network (ASHN) by calling 1-800-678-9133. You can also find out which chiropractors are network providers by calling ASHN or visiting the ASHN website at www.ashplans.com.

Acupuncture

Acupuncture services received from an M.D. or licensed acupuncturist will be covered at 80% for up to 20 visits per year for Network Access Plan (NAP) members who use a network acupuncturist, and for members of the Comprehensive Access Plan (CAP).

If NAP members do not use a network acupuncturist, the reimbursement rate will be 70% for up to 15 visits of Medically Necessary care.

Transplant Services

Organ and tissue transplants are covered at 100% for Network Access Plan (NAP) members and Comprehensive Access Plan (CAP) members when preauthorized and when performed at a Designated United Resource Network Facility.

If NAP members use a facility other than a Designated United Resource Network Facility, reimbursement will be limited to 70% of Reasonable and Customary expenses. Preauthorization is still required.

Cornea transplants do not require use of a Designated United Resource Network Facility.

To obtain information on Designated United Resource Network Facilities, contact UnitedHealthcare's Care Coordination at 1-877-842-4743.

Retiree Optional Plan (ROP)

The annual deductible for the Retiree Optional Plan (ROP) is being lowered from $500 per person to $400 per person. The maximum annual family deductible will decrease from $1,500 to $1,200.

In addition, the out-of-pocket maximum per person is being lowered from $5,000 to $4,000. The family out-of-pocket maximum will decrease from $10,000 to $8,000.

PG&E Medicare Supplemental Plan (MSP)

The PG&E Medicare Supplemental Plan (MSP) will be available in 2004 to all retirees who are over age 65 and eligible for Medicare. In the past, eligibility was limited to retirees who were covered by a bargaining unit agreement prior to retirement.

The lifetime maximum is increasing from $7,500 to $10,000 per person for medical benefits. Up to $1,000 of this amount will be automatically restored each year. The provision that allows the entire lifetime maximum to be restored with evidence of good health will no longer apply.

Prescription drug benefits, which in the past have been counted towards the MSP lifetime maximum, will now have a separate lifetime maximum of $10,000 per person. Up to $1,000 of this amount will be automatically restored each year. There will also be a separate annual deductible of $100 per person for prescription drugs. In addition, home delivery service is being added for MSP members. Prescription drugs purchased at retail stores will be reimbursed at 75% and prescriptions filled through home delivery will be reimbursed at 80%. A summary of the prescription drug benefits is provided in the section of this brochure called “Outpatient Prescription Drug Plan” beginning on page 16.

Supplemental Accident Benefit and Deductible Accident Provisions No Longer Apply

The Supplemental Accident Benefit and Deductible Accident Provisions, which are part of the current Point of Service, Preferred Provider Organization,

Out-of-Area, and PG&E Medicare Supplemental Plans, will not apply to the Network Access Plan (NAP), the Comprehensive Access Plan (CAP) or the PG&E Medicare Supplemental Plan (MSP).

Cancer Resource Services (CRS) for UnitedHealthcare Members

A new program – Cancer Resource Services (CRS) – is now available to members who have selected UnitedHealthcare as their medical plan administrator. Cancer Resource Services is designed to help members get the information they need to understand their cancer diagnosis and their treatment options. In addition, experienced CRS nurses can help members choose the best physician and cancer center for treatment of a specific kind of cancer.

Through this program, members also have access to top cancer specialists at premier cancer centers across the country and their clinical trials. These providers are considered “preferred network providers” for members enrolled in the NAP. CAP members are also eligible to use the services of CRS at their standard level of coverage for the services performed. Members may also be eligible for reimbursement for travel and lodging expenses when getting care at a CRS cancer center. To make the most of this new benefit, however, members must call CRS **before** receiving care at a participating CRS cancer center.

For additional information about Cancer Resource Services and participating cancer centers or for questions about a cancer diagnosis, please call a CRS nurse consultant toll-free at 1-866-936-6002. Nurses are available from 7 a.m. to 7 p.m. Central Time, Monday through Friday, excluding holidays. Or visit the Cancer Resource Services website at www.urncrs.com for more information about the products and services now available. This program is voluntary and free of cost.

Network Access Plan (NAP)

The chart below summarizes the benefits of the Network Access Plan (NAP).

Provisions	Network Access Plan (NAP) *Administered by UnitedHealthcare*	
	Preferred	Non-Preferred
Deductible	2004 - None 2005 and thereafter - $100 per person; $300 family maximum	2004 - $200 per person; $600 per family 2005 and thereafter - $200 per person; $600 per family
Annual Out-of-Pocket Maximum	$750 per person; $1500 family maximum	$1000 per person; $2000 family maximum
Lifetime Maximum	None	None
Hospital Stay	100% after a $100 copay Preauthorization required for non-emergency care; $300 penalty if not obtained	70% Preauthorization required for non-emergency care; $300 penalty if not obtained
Skilled Nursing Facility	90% Preauthorization required; $300 penalty if not obtained	70% Preauthorization required; $300 penalty if not obtained
Emergency Room Care	$35 copay per visit. Waived if admitted.	$35 copay per visit. Waived if admitted.
Outpatient Hospital	$35 copay per visit. Waived if admitted.	70%
Maternity Care	Covered as any other condition. Preauthorization of delivery stays beyond 48 hours for normal delivery and 96 hours for cesarean section; $300 penalty if not obtained	Covered as any other condition. Preauthorization of delivery stays beyond 48 hours for normal delivery and 96 hours for cesarean section; $300 penalty if not obtained
Well-Baby Care	Covered as any other condition	70%
Office Visits	Primary care - $10 copay Specialists (including OB/GYN) - $20 copay	70%
Urgent Care Visits	$10 or $20 copay, depending on if Primary care or Specialist visit	70%
Routine Physical Examinations	$10 or $20 per visit, depending on if Primary care or Specialist visit; lab/X-rays covered separately	70%
Immunizations and Injections	95%	70%
Eye Examinations	Note covered	Not covered
X-rays and Lab Tests	90%	70%
Pre-Admission Testing	95%	70%
Home Health Care & Home Hospice Care	90% Preauthorization required; $300 penalty if not obtained	70% Preauthorization required; $300 penalty if not obtained
Outpatient Physical Therapy	80%	70%
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health. (See page 20)	Covered by separate drug plan administered by Medco Health. (See page 20)
Mental Health	Covered by separate Mental Health Program	Covered by separate Mental Health Program
Inpatient and Outpatient Alcohol and Drug Care	Covered by separate Alcohol and Drug Care Program	Covered by separate Alcohol and Drug Care Program
Chiropractic Care	80% for care approved by American Specialty Health Network	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.
Fertility Benefits	Covered as any other condition up to $7,000 lifetime. Balances from prior plans carry forward.	Covered as any other condition up to $7,000 lifetime. Balances from prior plans carry forward.
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
Transplant Services	100% when performed at a Designated United Resource Network Facility. Preauthorization required.	70% if not performed at a Designated United Resource Network Facility. Preauthorization required.

Comprehensive Access Plan (CAP)

The chart below summarizes the benefits of the Comprehensive Access Plan (CAP).

Provisions	Comprehensive Access Plan (CAP) Administered by UnitedHealthcare
Deductible	2004 - None 2005 and thereafter - $100 per person; $300 family maximum
Annual Out-of-Pocket Maximum	$750 per person: $1500 family maximum
Lifetime Maximum	None
Hospital Stay	100% after a $100 copay Preauthorization required for nonemergency care; $300 penalty if not obtained
Skilled Nursing Facility	90% Preauthorization required; $300 penalty if not obtained
Outpatient Hospital and Emergency Room Care	$35 copay per visit. Waived if admitted.
Maternity Care	Covered as any other condition. Preauthorization of delivery stays beyond 48 hours for normal delivery and 96 hours for cesarean section; $300 penalty if not obtained
Well-Baby Care	Covered as any other condition
Office Visits	Primary care - $10 copay Specialists (including OB/GYN) - $20 copay
Urgent Care Visits	$10 or $20 copay, depending on if Primary care or Specialist visit
Routine Physical Examinations	$10 or $20 copay, depending on if Primary care or Specialist visit, lab/ X-rays covered separately
Immunizations and Injections	95%
Eye Examinations	Not covered
X-rays and Lab Tests	90%
Pre-Admission Testing	95%
Home Health Care & Home Hospice Care	90% Preauthorization required; $300 penalty if not obtained
Outpatient Physical Therapy	80%
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health. (See page 20)
Mental Health	Covered by separate Mental Health Program.
Inpatient and Outpatient Alcohol and Drug Care	Covered by separate Alcohol and Drug Care Program.
Chiropractic Care	80% for Medically Necessary care Preauthorization by American Specialty Health Network required after initial visit
Acupuncture	80% for up to 20 visits per year from licensed acupuncturist or M.D.
Fertility Benefits	Covered as any other condition up to $7,000 lifetime. Balances from prior plans carry forward.
Durable Medical Equipment	80% Preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained
Transplant Services	100% Preauthorization and use of Designated United Resource Network Facility required

Retiree Optional Plan (ROP)

The chart below summarizes the benefits of the Retiree Optional Plan (ROP).

Provisions	Retiree Optional Plan *Administered by UnitedHealthcare*
Deductible	$400 per person; $1,200 family maximum
Annual Out-of-Pocket Maximum	$4,000 per person; $8,000 annual maximum
Lifetime Maximum	None
Hospital Stay	70% after deductible Preauthorization required for non-emergency care; $250 penalty if not obtained
Skilled Nursing Facility	70% for semi-private room after 3 days in hospital
Outpatient Hospital and Emergency Room Care	70% after deductible
Office Visits	70% after deductible
Urgent Care Visits	70% after deductible
Routine Physical Examinations	70% after deductible
Immunizations and Injections	70% after deductible
Eye Examinations	Not covered
X-rays and Lab Tests	70% after deductible
Pre-Admission Testing	70% after deductible
Durable Medical Equipment	70% after deductible
Home Health Care & Home Hospice Care	70% after deductible Requires prior authorization
Inpatient Hospice Care	70% after deductible Requires prior authorization
Outpatient Physical Therapy	70% after deductible
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health. See page 20 for details.
Mental Health	
- **Inpatient Care**	70% after deductible
- **Outpatient Care**	70% after deductible
Alcohol and Drug Care	70% after deductible
Chiropractic Care	70% after deductible 10-visit maximum per year
Acupuncture	70% after deductible with prior approval from UnitedHealthcare
Other Benefits	Fertility-70% after deductible; $7,000 lifetime maximum. Hearing aids – 70% up to $2800 annually

PG&E Medicare Supplemental Plan (MSP)

The chart below summarizes the benefits of the PG&E Medicare Supplemental Plan (MSP).

Provisions	PG&E Medicare Supplemental Plan (MSP) *Administered by UnitedHealthcare*
Deductible	$100 deductible per person
Annual Out-Of-Pocket Maximum	None
Lifetime Maximum	$10,000 (up to $1,000 restored each year)
Hospital Stay	After deductible, 80% of eligible hospital expenses not covered by Medicare
Skilled Nursing Facility	After deductible, 80% of member copay amount per Medicare from 21st to 100th day of confinement
Outpatient Hospital and Emergency Room Care	After deductible, 80% of eligible expenses not covered by Medicare
Office Visits	After deductible, 80% of eligible expenses not covered by Medicare
Urgent Care Visits	After deductible, 80% of eligible expenses not covered by Medicare
Routine Physical Examinations	Not covered
Immunizations and Injections	Not covered
Eye Examinations	Not covered
X-rays and Lab Tests	After deductible, 80% of eligible expenses not covered by Medicare
Pre-Admission Testing	After deductible, 80% of eligible expenses not covered by Medicare
Home Health Care & Home Hospice Care	After deductible, 80% of eligible expenses not covered by Medicare
Inpatient Hospice Care	After deductible, 80% of eligible expenses not covered by Medicare
Outpatient Physical Therapy	After deductible, 80% of eligible expenses not covered by Medicare
Outpatient Prescription Drugs	Covered by separate drug plan administered by Medco Health. See page 20 for details.
Mental Health	
- Inpatient Care	After deductible, 80% of eligible expenses not covered by Medicare
- Outpatient Care	Not covered
Alcohol and Drug Care	Not covered
Chiropractic Care	After deductible, 80% of eligible expenses not covered by Medicare. Services must be Medically Necessary.
Acupuncture	Not covered
Durable Medical Equipment	After deductible, 80% of eligible expenses not covered by Medicare

Health Maintenance Organizations (HMOs)

Kaiser, Health Net and PacifiCare will continue to be offered as HMO options to retirees and dependents who reside in the appropriate service areas.

The Aetna HMO will no longer be offered. If you are enrolled in Aetna and do not select a new plan during Open Enrollment, you will be automatically switched to the Network Access Plan (NAP) or the Comprehensive Access Plan (CAP), depending on where you live.

Copayments in the HMOs are increasing to reflect the rising costs of health care. The copayments for office visits will increase from $5 to $10. There will also be some increases in copayments for other services, such as prescription drugs and emergency room care. These changes in copayments will vary by HMO. The copayments for HMO services in 2004 will be listed on the comparison charts included with your Open Enrollment information.

There is additional information on HMO coverage in the section of this booklet on Mental Health, Alcohol and Drug Care Benefits (see page 21).

Outpatient Prescription Drug Plan (for members of UnitedHealthcare-Administered plans)

Some important changes are being made to the Prescription Drug Plan administered by Medco Health. This Plan provides benefits to members enrolled in the Network Access Plan (NAP), Comprehensive Access Plan (CAP), Retiree Optional Plan (ROP), and the PG&E Medicare Supplemental Plan (MSP). Members enrolled in Heath Maintenance Organizations (HMOs) have drug coverage through their HMOs.

Because Medicare does not cover prescription drugs, this plan is the primary payor of prescription drug benefits for members who are enrolled in Medicare.

Prescription Drug Plan Changes for NAP and CAP Members

(Effective January 1, 2004)

Prescription drugs purchased at a participating retail pharmacy will continue to be reimbursed for up to three 30-day supplies at 85% for generic drugs and 75% for brand name drugs. **However, for retail refills beyond 90 days, the reimbursement rate will be 80% for generic and 70% for brand-name drugs**. Members will be reimbursed at 85% for the initial 30-day generic prescription, as well as for two 30-day refills at a retail pharmacy. If the member requests a fourth prescription at a retail pharmacy, the reimbursement rate will drop to 80% because the 90-day limit will have been exceeded. Therefore, **it is suggested that members use the home-delivery service for refills beyond 90 days.**

Prescription Drug Plan Changes for NAP, CAP and MSP Members

(Effective January 1, 2004)

Another important change is that for all prescription drug purchases, whether at a retail drug store or through home delivery, members will be responsible for paying the difference between the price of a generic prescription drug and a brand prescription drug, plus coinsurance, if purchasing a brand-name drug when a generic is available.

The example on the following page shows how the new "pay the difference" provision will work.

Example of Brand-Name Purchase vs. Generic:

Al purchases a 30-day supply of Prozac, a brand name prescription drug. He chooses not to use the generic alternative, Fluoxetine.

	GENERIC	***BRAND-NAME***
Drug Name and Price	Fluoxetine ($50.96)	Prozac ($152.41)
Copayment	$7.64 (15% of $50.96)	$38.10 (25% of $152.41)
Price difference between brand-name and generic	Not applicable	$152.41 - $50.96 = $101.45
Member's Total Cost	**$7.64**	$38.10 + $101.45 = **$139.55**
Extra cost for member to purchase brand-name drug = $131.91 ($139.55 - $7.64)		

If Al had elected to use the generic alternative, Fluoxetine, his copayment would have been 15% of the $50.96 price for the generic drug, or $7.64. However, because he chooses to purchase the brand-name drug (Prozac) when a generic is available, his copayment will be 25% of the higher price for the brand-name drug, or $38.10. In addition to this copayment, he must pay the full difference in price between the brand name and generic ($152.41 - $50.96 = $101.45). In total, Al must pay $139.55 for the brand-name prescription (copay of $38.10 plus the brand-generic price difference of $101.45). By purchasing the generic version, Al could have saved $131.91.

Certain brand name drugs will not be subject to the "pay the difference" penalty. These brand name drugs can be found on Medco Health's Narrow Therapeutic List. Only the 25% brand copayment will apply to these

brand-name prescription drugs. The list, which is subject to change, currently includes:

- Clozaril (clozapine)
- Coumadin (warfarin)
- Depakene (valproic acid)
- Branded digoxin (e.g. Lanoxin)
- Dilantin (phenytoin)
- Branded levothyroxine (e.g. Synthroid, Levothroid)
- Mysoline (primidone)
- Neoral (cyclosporine)
- Tegretol (carbamazepine)
- All sustained-released theophyllines

Any questions about the Narrow Therapeutic List can be directed to Medco Health at 1-800-718-6590.

Prescription Drug Plan
(Administered by Medco Health)

The chart below summarizes the outpatient drug benefits available to members of medical plans administered by UnitedHealthcare.

Provisions	*Retiree Optional Plan Members*	*NAP and CAP Plan Members*	*PG&E Medicare Supplemental Plan (MSP) Members*
Retail Drug Purchases	60% after deductible at any retail pharmacy	First three 30-day supplies at a participating pharmacy: 85% for generics, 75% for brand names. Refills beyond 90 days and coverage at non-participating pharmacies: 80% for generics and 70% for brand names.	Coverage is 75% after deductible of eligible expenses not covered by Medicare
Home Delivery (Mail-Order) Purchases	70% after deductible for 90-day supply	90% for generic drugs and 80% for brand name drugs.	80% after deductible for 90-day supply
Deductible	$200 per person; no family maximum. Retail and mail-order deductible is combined.	No deductible	$100 per person; no family maximum. Retail and mail-order deductible is combined.
Out-of-Pocket Maximum	$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; does not coordinate with medical plan.	$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; does not coordinate with medical plan.	None
Fertility, Sexual Dysfunction, Memory Enhancement and Birth Control Drugs	50% after deductible	50% for both retail and mail-order plan	Covered only to treat serious medical conditions.
Lifetime Maximum	None	None	$10,000 per person ($1,000 restored each year)
Generic Incentive	Not applicable	Member is responsible for paying the difference between the price of a generic prescription drug and a brand-name prescription drug, plus coinsurance, if purchasing a brand-name drug when a generic is available.	Member is responsible for paying the difference between the price of a generic prescription drug and a brand-name prescription drug, plus coinsurance, if purchasing a brand-name drug when a generic is available

Mental Health, Alcohol and Drug Care Benefits

Benefit Changes for Members of Network Access Plan (NAP) and Comprehensive Access Plan (CAP)

Members in the NAP and CAP Plans will receive mental health benefits through the Mental Health, Alcohol and Drug Care Program administered by ValueOptions. Effective January 1, 2004, the copayment for outpatient mental health visits received through this program is increasing from $10 to $15 per visit. Another change is that there will be no charge for the initial visit to a psychiatrist (M.D.) for medication evaluation.

HMOs

Members in HMOs receive mental health benefits through their HMOs. Copayments for mental health visits received through some HMO plans will increase in 2004. The new copayments for HMO services will be specified on the comparison charts included with your Open Enrollment information.

Beginning July 1, 2003, Kaiser members–with approval by ValueOptions–are eligible to receive inpatient or residential treatment for alcohol and drug abuse through the Mental Health, Alcohol and Drug Care Program. Kaiser members will continue to receive outpatient alcohol and drug care coverage through Kaiser.

PacifiCare and Health Net members currently receive alcohol and drug care benefits through the program administered through ValueOptions and also through their HMOs. In 2004, these benefits will only be available through the ValueOptions program, not through PacifiCare or Health Net.

Medicare members enrolled in either the Secure Horizons plan or the Health Net Seniority Plus plan will continue to receive alcohol and drug care benefits through their Medicare HMO, as well as through the ValueOptions program.

Retiree Benefits

Retirees Can Drop Coverage and Re-Enroll at a Later Date

Retirees who drop their PG&E medical plan coverage on or after January 1, 2003, will be allowed to re-enroll during future Open Enrollment periods. Retirees will be responsible for notifying the HR Service Center by September 1st if they wish to re-enroll for the upcoming year. An enrollment package will then be mailed to the retiree's home during the next Open Enrollment period.

Retirees who dropped PG&E Retiree Medical Plan coverage prior to January 1, 2003, and surviving dependents who drop coverage at any time are not eligible to re-enroll.

New Benefit – Retiree Premium Offset Account

Effective January 1, 2004, a new benefit – the Retiree Premium Offset Account – will be available to retirees who qualify. Current and future retirees with more than ten years of credited service at retirement will be eligible for the account, provided they are eligible to enroll in a PG&E medical plan. The account can be used to pay 50% of their PG&E monthly medical plan premiums. The Company will contribute up to $500 for each year of credited service beyond ten years, up to a lifetime maximum account balance of $7,500.

Your Open Enrollment materials will contain more information such as your personal account balance, how to initiate use of your account and the actual dollar reduction of your required premium contribution should you elect to use your account.

Please note the following:

- The Retiree Premium Offset Account has no cash value.
- You may only use this account to reduce the premiums of a PG&E-sponsored medical plan.

- You must actively enroll during Open Enrollment – by calling the HR Service Center or returning an enrollment form – if you want to use your account to offset 50% of your monthly medical plan premiums in 2004.
- If your account balance becomes depleted, you will be responsible for paying the full cost of your selected medical plan's premium at that time.
- Once depleted, your account balance will not be restored.
- You may elect to change your Retiree Premium Offset Account election only during a subsequent Open Enrollment period or if you experience a qualified mid-year change-in-status event.
- If you do not actively elect to change your account election during subsequent Open Enrollment periods, your current election will remain in effect for the upcoming plan year.

Example:

Barry retires with 22 years and 11 months of credited service. The calculation for his Retiree Premium Offset Account will take into account his years of credited service beyond ten years, multiplied by $500 per year. On a monthly basis, the $500 per year equates to $41.6666 per month.

Barry has 22 years and 11 months of credited service, so his credited service beyond ten years is 12 years and 11 months. Therefore, the formula for calculating his account balance is as follows:

12 years and 11 months = 155 months x $41.6666 = $6,458

Thus, Barry's account balance is $6,458. He can use this account to pay 50% of his medical premiums each month.

– NOTES –

WHERE TO GET HELP

Topic	Contact	Phone Number
Questions About Enrollment or Benefits	PG&E HR Service Center	1.800.700.0057
Directories	Please call the member services number listed below	
Social Security Administration		1.800.772.1213

MEMBER SERVICES NUMBERS

For information or provider directories, call the appropriate plan's number listed below.

Plan	Phone Number	Web Site
Health Net	1.800.522.0088	www.health.net
Health Net Seniority Plus	1.800.275.4737	www.health.net
Kaiser Permanente (North and South)	1.800.464.4000	www.kaiserpermanente.org
Kaiser Senior Advantage (North and South)	1.800.443.0815	www.kaiserpermanente.org
PacifiCare	1.800.624.8822	www.phs.com
PacifiCare Secure Horizons	1.800.228.2144	www.phs.com
PG&E Medical Plans (Administered by United Healthcare) - Network Access Plan (NAP) - Comprehensive Access Plan (CAP) - PG&E Medicare Supplemental Plan (MSP) - Retiree Optional Plan	1.877.842.4743	www.provider.uhc.com/pge - or - www.myuhc.com
American Specialty Health Network	1.800.678.9133	www.ashplans.com
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