

Human Resources
Benefits Open Enrollment

2012
Legal Supplement



GRANDFATHERED HEALTH PLAN NOTICE

The Pacific Gas and Electric Company Health Care Plan for Active Employees (except for the Health Savings Account Medical Plan for Management and A&T Employees option) is a “grandfathered health plan” under the Patient Protection and Affordable Care Act of 2010 (PPACA). As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that already was in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the PPACA that apply to other plans—for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the PPACA, such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to lose grandfathered status can be directed to the plan administrator: Pacific Gas and Electric Company Plan Administrator, Benefits Department, 1850 Gateway Boulevard, 7th Floor, Concord, CA 94520. Or, you may contact the Employee Benefits Security Administration, U.S. Department of Labor at **866-444-3272** or www.dol.gov/ebsa/healthreform. This website has a table summarizing the protections that apply to grandfathered health plans.

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Medicare Coverage

If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, please see page 23 for information about your prescription drug coverage and Medicare.

Introduction

This 2012 *Legal Supplement* includes detailed information about eligibility, change-in-status events and COBRA, as well as other legally required information for the following benefit programs:

- The Pacific Gas and Electric Company Health Care Plan for Active Employees
- The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents
- The Pacific Gas and Electric Company Health Care Reimbursement Account Plan
- The Pacific Gas and Electric Company Dependent Care Reimbursement Account Plan
- Pacific Gas and Electric Company Health and Welfare Benefits Pre-Tax Plan

Certain plans are referred to herein collectively as “PG&E’s Health Care Plans.” These are the plans that provide medical, mental health, prescription drug, dental and vision coverage, as well as the Health Care Reimbursement Account plans.

Participating Employers

The Employers participating in the 2012 Open Enrollment are Pacific Gas and Electric Company (PG&E), PG&E Corporation, PG&E Corporation Support Services, Inc., and PG&E Corporation Support Services II, Inc.

Eligibility

Eligibility for Employees

You and your eligible dependents may enroll in PG&E’s benefit plans if you are a full-time or part-time employee of a Participating Employer. Your eligibility for specific benefit plans is determined by these factors:

- Whether you are a Management and Administrative & Technical employee or union-represented employee
- Whether you work for PG&E Corporation, Pacific Gas and Electric Company or another Participating Employer
- Your home ZIP code

Eligibility for Retirees

For information regarding eligibility for PG&E-sponsored retiree medical benefits, please refer to the *January 2011 Summary of Benefits Handbook for Retirees and Surviving Dependents*.

RE-ENROLLING AFTER CANCELLING MEDICAL COVERAGE

Retirees who cancel medical plan coverage on or after January 1, 2003, may re-enroll in a PG&E-sponsored retiree medical plan during any subsequent Open Enrollment period. To initiate re-enrollment for 2013, you must call the HR Service Center to request an Open Enrollment packet **no later than September 1, 2012**. An enrollment packet will be mailed to your home immediately before 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, 2012, you will not be able to re-enroll for the upcoming year—even if you cancelled PG&E-sponsored coverage because you had other medical coverage and you subsequently lost that other coverage.

The only exception is if you're enrolled as a dependent of an active PG&E employee in a PG&E-sponsored medical plan. If you lose your dependent coverage midyear, you can enroll in retiree coverage midyear and you won't need to wait until the next Open Enrollment period to enroll.

NON-PAYMENT OF RETIREE MEDICAL PREMIUMS

If you are a retiree and do not pay your medical plan premiums or any required restitution for covering ineligible dependents, your coverage will be permanently cancelled and you will not be able to re-enroll in a PG&E-sponsored medical plan again.

Eligibility for Surviving Dependents

As a surviving dependent (spouse, registered domestic partner or eligible child) of an employee or retiree, you are eligible for continued medical plan coverage if you were enrolled in a PG&E-sponsored medical plan at the time of the employee's or retiree's death and you are not covered under another group plan (other than Medicare).

If you are a surviving child, you must meet additional eligibility criteria (contact the HR Service Center for more information).

IF YOU MARRY OR ESTABLISH A DOMESTIC PARTNERSHIP

Surviving dependents who marry or enter into a registered domestic partnership are not eligible to be covered under a PG&E-sponsored medical plan, even if the new spouse or registered domestic partner has no other medical coverage. If you marry or enter into a registered domestic partnership, please notify the HR Service Center immediately to avoid penalties.

CANCELLATION

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.

PREMIUMS

Surviving dependents generally pay the full cost of their required medical plan premiums; the Participating Employer makes no contribution toward the cost.

If you die as an active employee from injuries sustained in the course of your employment while performing your job and you are covered under a PG&E-sponsored medical plan, subject to the eligibility rules discussed in this section, your enrolled surviving dependents will be eligible for PG&E-paid coverage for up to six months. After six months, the surviving dependents may continue their PG&E-sponsored medical coverage by paying the full premium.

In addition, if at the time of your death you are covered under a PG&E-sponsored dental plan, vision plan or the Employee Assistance Program (EAP), your enrolled surviving dependents will be eligible to continue their coverage through PG&E-paid COBRA for up to six months. After six months and until expiration of COBRA coverage, the surviving dependents may continue their PG&E-sponsored dental, vision and EAP coverage by paying the full COBRA rate.

Note: Retirees who dropped PG&E-sponsored retiree medical plan coverage before January 1, 2003, are not eligible to re-enroll for PG&E-sponsored medical plan coverage at any time.

For more information about COBRA, see page 16.

NON-PAYMENT OF SURVIVING DEPENDENT MEDICAL PREMIUMS

If you are a surviving dependent and you do not pay your medical plan premiums or any required restitution for covering ineligible dependents, your coverage will be permanently cancelled and you will not be able to re-enroll in a PG&E-sponsored medical plan again.

Eligible Dependents

If both you and your spouse or registered domestic partner are an employee or retiree of a Participating Employer, only one of you may enroll each child as an eligible family member under any one benefit plan.

Eligible dependents include:

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

Federal law requires Social Security numbers (SSNs) for many eligible dependents. If a dependent SSN is listed as "Missing," on your Benefits Enrollment Worksheet, please contact the HR Service Center at **415-973-4357** or **800-788-2363** (retirees call **800-700-0057**), and provide the SSN.

MINI-MED PLANS

If your child under age 26 only has access to a "mini-med" plan offered by another employer, PG&E will allow you to enroll your eligible child as a dependent in your PG&E-sponsored health care coverage. Mini-med plans are medical plans that provide extremely limited coverage and have been granted an official waiver from the annual benefit caps on essential health benefits by the U.S. Department of Health and Human Services.

Your adult child should receive an annual notice of this waiver from his or her employer or health insurance issuer. You should keep a copy with your records, as you may be asked to submit this notice to PG&E to validate your child's eligibility for PG&E-sponsored coverage.

Tax Implications of Coverage for Your Adult Children

For federal and state income tax purposes in all states except Wisconsin, the value of health care coverage provided to your adult child is excluded from your income. In other words, it is not taxable.

For Wisconsin state income tax purposes, the value of the health care benefits provided for your adult child is treated as taxable income to you, unless your adult child is also your tax dependent. PG&E will report the value of the coverage as income on your *Form W-2* and may withhold the applicable taxes.

Domestic Partner Registration

If you want to add a domestic partner or the children of a domestic partner to your coverage, your partnership must be registered with a governmental agency that maintains a domestic partner registry.

Tax Implications of Coverage for Your Same-Sex Spouse, Registered Domestic Partner, and Children of Your Same-Sex Spouse or Registered Domestic Partner

FEDERAL TAXES

It is important to note that the value of the health care coverage provided for a registered domestic partner, same-sex spouse, or any enrolled children of a registered domestic partner or same-sex spouse may be treated as income to you for federal tax purposes. PG&E will report the value of the coverage as income on your *Form W-2* and will withhold federal income and employment taxes. The amounts taxable to you can be substantial.

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

CALIFORNIA TAXES

For California income tax purposes, the value of the health care benefits provided to your same-sex spouse and your same-sex spouse's dependents are excluded from your taxable income.

For California income tax purposes, the value of the health care benefits provided to your domestic partner and your domestic partner's dependents may be excluded from your taxable income if your partnership is registered with California's Secretary of State and if certain other conditions are met. Please contact your tax advisor and the HR Service Center for more information.

More Information about Registered Domestic Partners/ Same-Sex Spouses

If you're an active employee, you can find more information about domestic partner registration and benefits for registered domestic partners and same-sex spouses in *Your Guide to Domestic Partner Benefits at Pacific Gas and Electric Company* on PG&E's HR intranet site.

If you're an employee on Long-Term Disability or a retiree, please call the HR Service Center for a copy of the guide.

TAX INFORMATION FOR DOMESTIC PARTNERS AND SAME-SEX SPOUSES

Many registered domestic partners and same-sex spouses do not qualify as tax dependents. However, if your enrolled, registered domestic partner; same-sex spouse; or his or her enrolled children are your tax dependents and you complete a *Certification of Tax Dependency* form, the value of the health care benefits will not be reported as taxable income.

You must complete a new certification each year. If you don't receive a *Certification of Tax Dependency* form for the upcoming tax year, please call the HR Service Center to request a form. Forms received after December 31, 2011, will not be processed for 2012.

IMPORTANT:

Did you know that you may be eligible for state health care coverage premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)?

Please see the notice starting on page 20.

National Medical Support Notices

If a Participating Employer receives a court-ordered judgment or decree requiring you to cover an eligible dependent child, the child will be enrolled in your health care plans, pursuant to the court order or judgment. Coverage for the child will be effective the first of the month following enrollment by PG&E, and your health plan premium costs will be adjusted to reflect the coverage of the child, if applicable. If you are enrolled in a health maintenance organization (HMO) and your child does not live within your HMO's service area, you will be switched to the Network Access Plan (NAP) or the Comprehensive Access Plan (CAP), as applicable for your family's ZIP code, and you will be responsible for paying the required contributions associated with the NAP and CAP plans.

Domestic Partner Dependents

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

Ineligible Dependents

Ineligible dependents include but are not limited to:

- A divorced, legally separated, or non-legally state recognized common-law spouse, even if a court orders you to provide health care coverage
- A former domestic partner, or a domestic partner if your domestic partnership has not been formally registered with a valid registry
- Parents, stepparents, parents-in-law, grandparents and stepgrandparents
- Former stepchildren or the stepchildren of a former registered domestic partner, unless they were born or adopted during the course of the registered domestic partnership or you have been appointed permanent legal guardian for them by a court
- Children age 19 through 25 who are eligible for coverage under an employer-sponsored health plan, such as through their own employer's plan or through their spouse or domestic partner's employer's plan (eligibility for coverage under another parent's group health plan does not count for this purpose). Unmarried children who are full-time students remain eligible for coverage whether or not they are offered other employer-sponsored coverage.

- Children age 26 and older, unless they have been approved for continued coverage under the Disabled Dependent provision for PG&E-sponsored medical plans
- Children who have entered the military (regardless of age or disability status)
- A spouse, common-law spouse, or domestic partner of your eligible child
- Children covered as dependents under the plan of another employee or retiree of a Participating Employer
- Grandchildren, nieces, nephews or other family members, unless you have legally adopted them or have been appointed permanent legal guardian for them by a court
- A family member who is a union-represented employee if you are a Management or A&T employee of a Participating Employer, or a family member who is a Management or A&T employee if you are a union-represented employee of a Participating Employer

Penalties for Covering Ineligible Dependents

Remember, it is your responsibility to be sure all the dependents you enroll for coverage are eligible. You must drop dependents from coverage within 31 days of the date on which they become ineligible for coverage. All participants who cover ineligible dependents will be required to make restitution to the Participating Employer for health care coverage, up to two full years' of the insured (or HMO) premiums or self-insured premium equivalents.

If you are a retiree or surviving dependent and you do not pay your required restitution for covering an ineligible dependent, your coverage will be permanently cancelled and you will not be able to re-enroll in a PG&E-sponsored medical plan again.

To drop ineligible dependents, call the HR Service Center at the phone number shown on the back cover.

When You Can Enroll

You have an opportunity to choose which PG&E benefits you'd like to participate in:

- **During the annual Open Enrollment period** (two weeks each year in the fall). Changes you make during Open Enrollment become effective January 1 of the following year.
- **When you experience an eligible change-in-status event**, such as marriage or the birth of a child. You must report eligible change-in-status events 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. Midyear change-in-status events do not apply to retirees or surviving dependents who are not already enrolled in a PG&E-sponsored medical plan at the time of the status change. See page 12 for more information.
- **If you're an employee who is eligible to participate in PG&E benefits, you can enroll when you're first hired by a Participating Employer.** You must complete the benefits enrollment form included in your benefits enrollment kit and return it to the HR Service Center within 31 calendar days of your hire date in order to have coverage. Elections you make generally become effective the first of the month following receipt of your elections. See page 9 for details about what happens if you don't enroll in coverage within 31 days.

During Open Enrollment

Depending on your employment status, you have these options for enrolling or making changes to your coverage during Open Enrollment:

YOUR EMPLOYMENT STATUS	COMPANY INTRANET: <i>PG&E@Work For Me</i> Accessible from home via Citrix or VPN	INTERNET: https://myportal.pge.com Must use Internet Explorer version 7.0 or lower	PHONE: HR Service Center
<ul style="list-style-type: none"> • Active Management and A&T employees who are not chiefs (supervisors) or delegates • Active ESC-represented employees 	✓	✓	
<ul style="list-style-type: none"> • Active IBEW- or SEIU-represented employees 	✓	✓	✓ 415-973-4357 800-788-2363
<ul style="list-style-type: none"> • Active Management and A&T employees who are chiefs (supervisors) or delegates* 	✓		
<ul style="list-style-type: none"> • Employees on Long-Term Disability, leave of absence or Workers' Compensation 	✓	✓	✓ 415-973-4357 800-788-2363 <i>See Guidelines for Employees on Leave of Absence on page 10 for details</i>
<ul style="list-style-type: none"> • Retirees and surviving dependents 		✓	✓ 415-972-7077 800-700-0057

*SAP role assignments require chiefs and delegates to enroll through Citrix or VPN.

If You Don't Enroll

The following tables show what will happen to your PG&E-sponsored benefit coverage if you don't enroll during Open Enrollment or when first eligible for benefits:

FOR EMPLOYEES		
If you're . . .	And you take no action . . .	Then . . .
Currently enrolled in medical, dental or vision coverage	During Open Enrollment	<ul style="list-style-type: none"> You'll continue to receive the same medical, dental and vision coverage that you and your covered dependents have in 2011, as listed on your 2012 Enrollment Worksheet. You'll be responsible for making any required premium contributions, as listed on your 2012 Enrollment Worksheet. You won't be able to participate in the Health Care Reimbursement Account (HCRA) or Dependent Care Reimbursement Account (DCRA) for 2012. Management and A&T employees won't be able to purchase Vacation Buy Days.*
Currently enrolled in the Supplemental Life Insurance Plan	During Open Enrollment	<ul style="list-style-type: none"> Management and A&T employees: You'll continue to receive the same Supplemental Life insurance coverage you have in 2011, as listed on your 2012 Enrollment Worksheet. You'll be responsible for making any required premium contributions, as listed on the 2012 worksheet. Regular-status union-represented employees: You can request to buy or change Supplemental Life insurance coverage at any time during the year by contacting MetLife. Supplemental Life insurance changes are not part of your Open Enrollment elections.
Not currently enrolled in medical, dental or vision coverage	During Open Enrollment	<ul style="list-style-type: none"> You'll have no medical, dental or vision coverage for 2012. You won't be able to participate in the Health Care Reimbursement Account (HCRA) or Dependent Care Reimbursement Account (DCRA) for 2012. Management and A&T employees won't be able to purchase Vacation Buy Days.* Management and A&T employees will receive Basic Life insurance coverage of \$10,000. Regular-status union-represented employees will receive Basic Life insurance coverage of \$10,000. All employees will receive EAP benefits.
Not currently enrolled in the Supplemental Life Insurance Plan	During Open Enrollment	<ul style="list-style-type: none"> Management and A&T employees will have no Supplemental Life insurance coverage. Regular-status union-represented employees can request to buy or change Supplemental Life Insurance coverage at any time during the year by contacting MetLife. Supplemental Life Insurance changes are not part of your Open Enrollment elections.
A newly hired PG&E employee This information applies to full-time or part-time employees of PG&E Corporation, Pacific Gas and Electric Company and any other covered affiliate.	Within 31 days of your hire date	<ul style="list-style-type: none"> You won't be eligible for health care coverage for the remainder of the year. Management and A&T employees will receive Basic Life insurance coverage of \$10,000. Regular-status union-represented employees will receive Basic Life insurance coverage of \$10,000. All employees will receive EAP benefits. <p>As an employee, your next opportunity to enroll for health care coverage will be the next annual Open Enrollment period or if you experience a HIPAA special enrollment event, whichever occurs first.</p>

*Vacation Buy Days are not available to union-represented employees.

If You Don't Enroll (continued)

FOR RETIREES AND SURVIVING DEPENDENTS		
If you're ...	And you ...	Then ...
Currently enrolled in a PG&E-sponsored retiree medical plan	Make no changes to your medical plan or covered dependents during Open Enrollment	<ul style="list-style-type: none"> You'll continue to receive your current 2011 medical coverage for yourself and your eligible, covered dependents, as listed on your 2012 Enrollment Worksheet. You'll be responsible for making any required premium contributions for you and your dependents' medical plan coverage, as listed on your 2012 Enrollment Worksheet.
Not currently enrolled in a PG&E-sponsored retiree medical plan	Don't enroll during Open Enrollment	<ul style="list-style-type: none"> You'll have no PG&E-sponsored retiree medical coverage for 2012.

FOR EVERYONE

If your medical plan is not available

If your current medical plan no longer will be available in 2011, your Enrollment Worksheet will indicate with an asterisk (*) the alternative medical plan you'll automatically receive for 2012 if you don't enroll. You'll be responsible for making any required contributions, as listed on your 2012 Enrollment Worksheet.

Guidelines for Employees on Leave of Absence

If you're on a leave of absence, special enrollment guidelines apply to you:

Your Contributions for Health Care Coverage: The amounts you pay for coverage vary depending on your leave of absence and whether you were a union-represented employee or Management or A&T employee prior to your leave. For union-represented employees, the rates also vary based on whether you were a full-time or part-time employee prior to your leave.

- **If you have been on medical leave for fewer than 12 months or you're on an emergency military leave:**
 - **Full-time union-represented employees and full-time or part-time Management and A&T employees** will pay the same amount for health care coverage as an employee who works full-time will pay.
 - **Part-time union-represented employees** will pay an amount that reflects their part-time status before going on leave.
- **If you're a Management or A&T employee on a personal leave, educational leave or regular military leave, you'll pay:**
 - **First three months:** The same amount for medical and dental coverage as an employee who works full-time will pay.
 - **Subsequent months:** 100 percent of the cost of medical coverage.
- **If you're a union-represented employee on a personal leave, educational leave or regular military leave, you'll pay:**
 - **First three months:** The same amount for coverage as an employee on medical leave will pay, which varies depending on your full-time or part-time status before the start of your leave.
 - **Subsequent months:** 100 percent of the cost of coverage.

The rates shown on your personalized Enrollment Worksheet reflect your portion of the medical plan contributions for each available medical plan option. The rate will be deducted from your pay when you return to work or you'll be billed on a monthly basis, depending on the election you make when you begin your leave.

- **If you're on a medical leave** that will continue into 2012 and you're being billed for your premium contributions, you'll be billed at the new rate, as shown on your Enrollment Worksheet, beginning January 1, 2012.
- **If you're on a personal leave (including child care leave)** and paying the full premium, or if you'll start the fourth month of your leave in January 2012, you'll be responsible for paying the rate shown on your Enrollment Worksheet.

- **If you elect to defer payment of your premium contributions while on leave,** the 2012 amounts listed on your Enrollment Worksheet will begin accruing effective January 1, 2012. All deferred premium contributions will be deducted from your pay when you return to work, in addition to your regular premium contributions.

Dependent Care Reimbursement Account (DCRA): You're not eligible to participate in the DCRA while on leave, but you'll have an opportunity to participate when you return to work.

Health Care Reimbursement Account (HCRA): If you're on an unpaid leave of absence, you may elect to contribute to the HCRA for 2012 on an after-tax basis. If you elect this option, you'll receive a *Health Care Reimbursement Account Election While on a Leave of Absence* form soon after you enroll. You must complete this form and return it to the HR Service Center within 15 days of receipt. Send it to the address on the form.

Health Savings Account (HSA): If you're enrolled in the HSA Medical Plan and were contributing to the HSA before your unpaid leave began, your payroll contributions will stop. However, you may continue contributing to your HSA on an after-tax basis as long as you remain enrolled in the HSA Medical Plan. To contribute, you'll need to electronically transfer funds to ConnectYourCare or send checks to UMB Bank, n.a., the HSA banking custodian. If you want to contribute directly to your HSA, you'll need to use after-tax dollars and later deduct your contributions from your federal income taxes. It is your responsibility to ensure that your total contributions for the year do not exceed the total annual federal limit. When you return to work, please call the HR Service Center if you'd like to restart payroll contributions. For more information, visit www.connectyourcare.com/pge.

Management and A&T employees are not eligible for the Vacation Buy policy.

Contact the HR Service Center if you have questions. Representatives are available Monday through Friday, 7:30 a.m. to 5 p.m. Pacific Time.

How Your Leave Status May Affect Your Coverage

If you return to work before the end of 2011:

The 2011 health care elections you made before your leave, including your DCRA (but not including your HCRA), if applicable, will automatically resume the first of the month following your return to work. DCRA contributions will be taken at the same monthly rate as before your leave, unless you made changes due to an eligible change-in-status event. DCRA expenses for services incurred during your unpaid leave will not be eligible for reimbursement.

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

Any elections you make during the annual Open Enrollment period will become effective January 1, 2012. If you make no changes during Open Enrollment, you and your eligible enrolled dependents will continue to be enrolled in the plans you were enrolled in prior to your leave. However, you will not be able to participate in the Flexible Spending Accounts (HCRA or DCRA) in 2012 unless you have an eligible change-in-status event. In addition, Management and A&T employees will not be able to purchase any Vacation Buy Days in 2012.

If you return to work in 2012:

If you make no changes during Open Enrollment, effective January 1, 2012, you and your eligible enrolled dependents will continue to have the same medical coverage you have in 2011. You'll be responsible for making any required contributions as listed on your 2012 Enrollment Worksheet.

When you return to work, you'll receive another enrollment packet and you'll be able to change your benefit and coverage elections for the remainder of 2012. Any changes you elect will take effect the first of the month following receipt of your elections, provided the HR Service Center receives your elections within 31 days of the date on which you return to work. In addition to changing health care coverage, you'll be able to:

- Add eligible dependents acquired during your leave
- Enroll in the HCRA if you didn't enroll in this account during Open Enrollment
- Enroll in the DCRA if your needs for dependent care changed because you returned to work

In addition, Management and A&T employees will be able to purchase up to five Vacation Buy Days.

If you make no elections for yourself and your eligible dependents within 31 days of your return to work, you'll have the same coverage you elected during Open Enrollment or the same coverage you had while on leave, if you made no changes during Open Enrollment. You won't be able to participate in the HCRA or DCRA in 2012. In addition, Management and A&T employees won't be able to purchase any Vacation Buy Days in 2012.

Changing Coverage During the Year (Change-in-Status Events)

If you experience an eligible change-in-status event such as marriage or divorce, you have 31 days to make any allowable changes to your benefits (60 days for the birth or adoption of a child). Otherwise, you may not be able to make changes until the next Open Enrollment period.

If you're a retiree or surviving dependent, you must be currently enrolled in a PG&E-sponsored medical plan to request a benefit change due to a change-in-status event.

To request an allowable benefit change due to a change-in-status event, you must call the HR Service Center within 31 days (60 days for the birth or adoption of a child) of the date of the event. Representatives are available Monday through Friday, 7:30 a.m. to 5 p.m. Pacific Time.

What's a Change-in-Status Event?

After you have enrolled for benefits, you will not be able to make changes to your coverage until the next Open Enrollment period unless you experience an eligible change-in-status event or you retire.

Only certain change-in-status events are recognized and only limited changes in your benefit elections are permitted, due to restrictions imposed by federal law governing the administration of before-tax benefit plans like those sponsored by PG&E. For example, for active employees, your before-tax contributions, such as amounts contributed to your Health Care Reimbursement Account (HCRA), cannot be altered due to a change in status relating to a domestic partnership or same-sex spouse. Eligible change-in-status events are listed below.

Any change you request must be consistent with your change-in-status event. For example, if you move out of your HMO's service area, you may change your medical plan, but you cannot add new dependents.

See "HIPAA Special Enrollment Rights for Employees" on page 15 for certain other permissible midyear coverage changes.

ELIGIBLE CHANGE-IN-STATUS EVENTS

Change-in-status events include:

- Marriage or the establishment of a registered domestic partnership (for employees and retirees only)
- Dissolution of marriage (including final divorce or annulment), legal separation or termination of a registered domestic partnership (please note that you cannot enroll your ex-spouse or former registered domestic partner in your PG&E-sponsored health care plan, even if a court orders you to provide coverage)
- The birth or adoption of a child, or your court-ordered appointment of legal guardianship for a child
- The death of your spouse, registered domestic partner or child
- Your child reaching the plan's age limit or entering the military
- You or your dependent becoming eligible for Medicare or Medicaid
- A change of caregivers or a change in the cost for the services of a caregiver who is not a relative (for Dependent Care Reimbursement Account purposes only)
- A move out of your HMO's service area (applies to change of medical plan only)
- A change in the employment of your spouse, registered domestic partner or dependent that results in a gain or loss of health care coverage
- A change to or from full-time or part-time employment by you, your spouse, registered domestic partner or dependents, if health plan eligibility is affected (this change-in-status event also is allowed for retirees, but only if they are already enrolled in a PG&E-sponsored health plan)
- The retirement of your PG&E active employee spouse or registered domestic partner if you are covered as his or her dependent
- An unpaid leave of absence taken by you, your spouse or registered domestic partner that significantly affects the cost of your health care coverage (this change-in-status event also is allowed for retirees who are already enrolled in a PG&E-sponsored health plan and whose spouse or registered domestic partner takes an unpaid leave of absence)

More information about change-in-status events is available on the HR intranet and in the *Summary of Benefits Handbook*.

IMPORTANT:

If you are a retiree who cancelled medical plan coverage on or after January 1, 2003, you may re-enroll in a PG&E-sponsored retiree medical plan only during subsequent Open Enrollment periods. You may not enroll at any other time, even if you have what would otherwise be considered a midyear change-in-status event, unless you currently are a covered dependent of an active employee who retires and is enrolled in a PG&E-sponsored health care plan. See "Re-Enrolling after Cancelling Medical Coverage" on page 2.

Federal law allows coverage changes due to change-in-status events relating to domestic partners or same-sex spouses only if they affect or relate to after-tax benefits, not before-tax benefits.

Call the HR Service Center within 31 days of a change-in-status event (60 days for births and adoptions) that may affect your benefits.

If you do not notify the HR Service Center within 31 days of the event (60 days for births and adoptions), you will not be able to make any changes until the next Open Enrollment period.

Benefit changes resulting from a change-in-status event will be effective the first of the month following the date you notify the HR Service Center, except when you are adding newborns and newly adopted children. Benefit changes related to births and adoptions will be effective on the date of the birth or the date you assume physical custody or financial responsibility for the adopted child.

IF YOUR MEDICAL PROVIDER NETWORK CHANGES

If any of your primary care physicians, specialists, medical groups, Independent Practice Associations (IPAs), hospitals or other providers withdraw from your medical plan during 2012, you will not be able to change medical plans.

Instead, you'll 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.

MOVE OUT OF HMO SERVICE AREA

If you or your dependent move out of your HMO's service area—for example, if your enrolled child begins attending college outside of your HMO's service area—you may change the medical plan that you and your dependents are enrolled in.

You must call the HR Service Center within 31 days to select a new medical plan. If you don't, the medical services you or your dependents receive may not be covered. See the *Summary of Benefits Handbook* for more details.

IMPORTANT INFORMATION ABOUT ADDING NEWBORN AND NEWLY ADOPTED CHILDREN

To ensure your newborn or newly adopted child has continuous health coverage from birth or adoption, you must call the HR Service Center **within 60 days** of your child's birth or adoption to enroll the child in your health plan. If you don't call within 60 days, any health care expenses incurred by your child will not be covered and your child's coverage will be cancelled:

- On the 61st day for the Anthem Blue Cross medical plans; or
- Retroactive to the date of birth or adoption for the HMO plans

Your next opportunity to enroll your child for PG&E-sponsored health plan coverage will be the next Open Enrollment period. Benefit changes made during Open Enrollment are effective January 1 of the following year.

Loss of Dependent Eligibility

You must drop ineligible dependents from coverage under PG&E-sponsored health plans within 31 days of a dependent's loss of eligibility. Employees of PG&E and other Participating Employers, and retirees who cover ineligible dependents will be required to make restitution to the company for the associated costs of providing health care coverage, up to two full years' of premiums or premium equivalents.

Your adult children will remain eligible for PG&E-sponsored medical plan coverage until the end of the month in which they reach age 26 or, if they become eligible for other employer-sponsored coverage, until the end of the month in which their other employer-sponsored coverage begins. At that time, they can enroll in extended coverage through COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). In accordance with federal law, they'll be required to pay 102 percent of the cost of COBRA coverage. For more information about COBRA, see page 16.

Disabled Dependent Certification

If you have eligible dependents who are under age 26, disabled and currently enrolled in a PG&E-sponsored medical plan, you must contact the medical plan vendor directly to request certification of ongoing eligibility due to a disability before your disabled dependent otherwise loses eligibility when he or she reaches age 26. If you do not complete the certification by a PG&E-sponsored medical plan on time, your disabled dependent no longer can continue to be enrolled in the plan, effective the first of the month following the month in which he or she reaches age 26. You also may be required to periodically attest to ongoing eligibility based on disability, after the initial certification.

HIPAA Special Enrollment Rights for Employees

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you decline PG&E-sponsored medical, dental or vision coverage for yourself or your dependents because you have other health insurance coverage, you may be able to enroll yourself and your dependents in a PG&E-sponsored health care plan if you are an employee and:

- You or your dependents lose eligibility for the other coverage
- The other employer stops contributing toward the other coverage
- You or your dependents meet or exceed the lifetime limit on benefits payable under the other plan
- You or your dependents lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage
- You or your dependents become eligible for a state's premium assistance program under Medicaid or CHIP

In addition, if you are an employee, you may be able to enroll yourself and your dependents in a PG&E-sponsored health care plan when:

- You have a newly eligible dependent due to marriage, establishment of a registered domestic partnership, birth, adoption or placement for adoption of a child

You must request enrollment by contacting the HR Service Center:

- **Within 31 days** after the other coverage ends or the employer stops contributing to the other coverage
- **Within 31 days** of your marriage or domestic partnership registration
- **Within 60 days** of the birth, adoption or placement for adoption of a child
- **Within 60 days** of the Medicaid/CHIP eligibility change

For more information or to request special enrollment, contact the HR Service Center.

IMPORTANT:

If you divorce, legally separate or dissolve a registered domestic partnership, or if a child no longer qualifies as an eligible dependent under the plans, you must call the HR Service Center to request COBRA enrollment materials **within 60 days** of the COBRA-qualifying event or the last day of eligible coverage—whichever occurs last.

An HR Service Center representative will give you a COBRA Notification Confirmation Number, which you should keep until you have received your COBRA enrollment materials. This number will serve as confirmation that you provided timely notification, as required by PG&E policy.

COBRA

When You or Your Dependents Lose Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows you and your enrolled dependents to continue PG&E-sponsored health care coverage if you lose coverage due to a COBRA-qualifying event. You can continue coverage under COBRA for up to 18 or 36 months, depending on the event. You pay the full cost of COBRA coverage.

COBRA-Qualifying Events

You or your dependents qualify for COBRA coverage if you or your dependents lose PG&E-sponsored health care coverage due to:

- Termination of your employment (for any reason other than gross misconduct)
- A reduction in work hours
- A change in your employment status from full-time to part-time
- Your death while enrolled as a plan participant
- Divorce or legal separation from your opposite-sex spouse
- Loss of eligibility by your child

PG&E and the other Participating Employers extend the same type of coverage rights to same-sex spouses, registered domestic partners, and their children that they would extend to qualified beneficiaries under COBRA. Qualifying events to obtain this COBRA-like coverage are the same for registered domestic partners and same-sex spouses as for opposite-sex spouses. For example, the dissolution of a registered domestic partnership or of a same-sex marriage is a qualifying event for obtaining COBRA-like coverage.

Qualified dependents must be enrolled in your health care plan immediately prior to the actual qualifying event. Dependents who are dropped during Open Enrollment may not qualify for continued coverage under COBRA because dropping coverage during Open Enrollment does not constitute a COBRA-qualifying event. If you are dropping a dependent during Open Enrollment and you're not sure whether your dependent is eligible for COBRA due to a qualifying event, please contact the HR Service Center at the phone number shown on the back cover.

If you are an employee and die or lose health coverage through PG&E or another Participating Employer, Ceridian (the COBRA administrator) will automatically provide you or your dependents with COBRA enrollment materials. If you are a retiree and die, your dependent should contact the HR Service Center.

When Your COBRA Coverage Ends

COVERAGE UNDER BLUE SHIELD, HEALTH NET AND KAISER PERMANENTE HMO* PLANS

If, on or after January 1, 2003, you had a COBRA-qualifying event that allowed for 18 months of continuation coverage in your HMO under federal law, California law (Cal-COBRA) allows an additional 18 months of continuation coverage through your HMO when your federal COBRA coverage ends. Additionally, Cal-COBRA allows those who exhaust their 36 months of COBRA continuation coverage to apply for a HIPAA Guaranteed Issue individual plan. To obtain these extended coverages through Cal-COBRA, you must send a written request to your HMO within the HMO's specified timeframe. For application materials, cost or additional information, contact your HMO at least 60 days before your current COBRA coverage terminates. The cost and coverage of any HIPAA Guaranteed Issue individual plan may vary considerably from your COBRA plan.

*** Effective January 1, 2012, the Kaiser Permanente HMO applies only to retirees and surviving dependents, employees on Long-Term Disability, and their enrolled dependents.**

COVERAGE UNDER ANTHEM BLUE CROSS ADMINISTERED PLANS AND KAISER PERMANENTE EXCLUSIVE PROVIDER ORGANIZATION** PLANS

If you're an Anthem Blue Cross member or a member of the Kaiser Permanente Exclusive Provider Organization (EPO) plan and your COBRA coverage is ending, you may contact your health plan to request coverage under a HIPAA Guaranteed Issue plan. Contact Anthem Blue Cross or Kaiser Permanente at least 60 days before your COBRA coverage ends. The cost and coverage of any HIPAA Guaranteed Issue individual plan may vary considerably from your COBRA plan.

**** Effective January 1, 2012, the Kaiser Permanente EPO applies to all active employees and their enrolled dependents.**

Important Legal Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

This notice is to remind you of the availability of the HIPAA Notice of Health Information Privacy Practices (“HIPAA Notice”) for The Pacific Gas and Electric Company Health Care Plan for Active Employees, The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, and The Pacific Gas and Electric Company Health Care Reimbursement Account Plan (“The Health Care Plans”). The HIPAA Notice was updated in January 2010.

The HIPAA Notice is posted on the HR intranet site in the **Plans, Policies & Forms** section or is available upon request. It describes how personal health information about you on file with The Health Care Plans may be used and disclosed, as well as how you can access your personal health information. In general, your individual health information may be used and disclosed by The Health Care Plans for purposes of treatment, payment and operations, as well as other uses and disclosures allowed or required by law.

For more information about The Health Care Plans’ health information privacy practices or HIPAA rights, or if you or your eligible dependents have questions about the HIPAA Notice, contact the Pacific Gas and Electric Company Plan Administrator, Benefits Department, 1850 Gateway Boulevard, 7th Floor, Concord, CA 94520.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but who need assistance paying their health premiums.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan—as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2011. You should contact your own state for more information on eligibility.

ALABAMA—Medicaid

Website: <http://www.medicaid.alabama.gov>

Phone: 800-362-1504

ALASKA—Medicaid

Website: <http://health.hss.state.ak.us/dpa/programs/medicaid/>

Phone (Outside of Anchorage): 888-318-8890

Phone (Anchorage): 907-269-6529

ARIZONA—CHIP

Website: <http://www.azahcccs.gov/applicants/default.aspx>

Phone (Outside of Maricopa County): 877-764-5437

Phone (Maricopa County) 602-417-5437

CALIFORNIA—Medicaid

Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx

Phone: 866-298-8443

COLORADO—Medicaid and CHIP

Medicaid Website: <http://www.colorado.gov/>

Medicaid Phone (In state): 800-866-3513

Medicaid Phone (Out of state): 800-221-3943

CHIP Website: <http://www.CHPplus.org>

CHIP Phone: 303-866-3243

FLORIDA—Medicaid

Website:

<https://www.flmedicaidtplecovery.com/>

Phone: 877-357-3268

GEORGIA—Medicaid

Website: <http://dch.georgia.gov/>

Click on Programs, then Medicaid

Phone: 800-869-1150

IDAHO—Medicaid and CHIP

Medicaid Website:
www.accesstohealthinsurance.idaho.gov
 Medicaid Phone: 800-926-2588
 CHIP Website: www.medicaid.idaho.gov
 CHIP Phone: 800-926-2588

INDIANA—Medicaid

Website: <http://www.in.gov/fssa>
 Phone: 800-889-9948

IOWA—Medicaid

Website: www.dhs.state.ia.us/hipp/
 Phone: 888-346-9562

KANSAS—Medicaid

Website: <http://www.kdheks.gov/hcf/>
 Phone: 800-792-4884

KENTUCKY—Medicaid

Website: <http://chfs.ky.gov/dms/default.htm>
 Phone: 800-635-2570

LOUISIANA—Medicaid

Website: <http://www.lahipp.dhh.louisiana.gov>
 Phone: 888-695-2447

MAINE—Medicaid

Website: <http://www.maine.gov/dhhs/OIAS/public-assistance/index.html>
 Phone: 800-572-3839

MASSACHUSETTS—Medicaid and CHIP

Medicaid & CHIP Website:
<http://www.mass.gov/MassHealth>
 Medicaid & CHIP Phone: 800-462-1120

MINNESOTA—Medicaid

Website: <http://www.dhs.state.mn.us/>
Click on Health Care, then Medical Assistance
 Phone (Outside of Twin City area):
 800-657-3739
 Phone (Twin City area): 651-431-2670

MISSOURI—Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/hipp.htm>
 Phone: 573-751-2005

MONTANA—Medicaid

Website: <http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml>
 Phone: 800-694-3084

NEBRASKA—Medicaid

Website: <http://www.dhhs.ne.gov/med/medindex.htm>
 Phone: 877-255-3092

NEVADA—Medicaid

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

NEW HAMPSHIRE—Medicaid

Website: <http://www.dhhs.nh.gov/ombp/index.htm>
 Phone: 603-271-4238

NEW JERSEY—Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
 Medicaid Phone: 800-356-1561
 CHIP Website: <http://www.njfamilycare.org/index.html>
 CHIP Phone: 800-701-0710

NEW YORK—Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/
 Phone: 800-541-2831

NORTH CAROLINA—Medicaid

Website: <http://www.nc.gov>
 Phone: 919-855-4100

NORTH DAKOTA—Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
 Phone: 800-755-2604

OKLAHOMA—Medicaid and CHIPWebsite: <http://www.insureoklahoma.org>

Phone: 888-365-3742

OREGON—Medicaid and CHIPWebsite: <http://www.oregon.gov/OHA/OPHP/FHIAP/index.shtml>

Phone: 888-564-9669

PENNSYLVANIA—MedicaidWebsite: <http://www.dpw.state.pa.us/hipp>

Phone: 800-692-7462

RHODE ISLAND—MedicaidWebsite: www.dhs.ri.gov

Phone: 401-462-5300

SOUTH CAROLINA—MedicaidWebsite: <http://www.scdhhs.gov>

Phone: 888-549-0820

TEXAS—MedicaidWebsite: <https://www.gethipptexas.com/>

Phone: 800-440-0493

UTAH—Medicaid and CHIPWebsite: <http://health.utah.gov/upp>

Phone: 866-435-7414

VERMONT—MedicaidWebsite: <http://www.greenmountaincare.org/>

Phone: 800-250-8427

VIRGINIA—Medicaid and CHIP

Medicaid Website:

<http://www.dmas.virginia.gov/rcp-HIPP.htm>

Medicaid Phone: 800-432-5924

CHIP Website: <http://www.famis.org/>

CHIP Phone: 866-873-2647

WASHINGTON—MedicaidWebsite: <http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm>

Phone: 800-562-3022 ext. 15473

WEST VIRGINIA—MedicaidWebsite: <http://www.dhr.wv.gov/bms/>

Phone: 304-558-1700

WISCONSIN—MedicaidWebsite: <http://www.badgercareplus.org/pubs/p-10095.htm>

Phone: 800-362-3002

WYOMING—MedicaidWebsite: <http://www.health.wyo.gov/healthcarefin/index.html>

Phone: 307-777-7531

To see if any more states have added a premium assistance program since July 31, 2011, or for more information on special enrollment rights, you can contact either:

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

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

PACIFIC GAS AND ELECTRIC COMPANY MEDICARE PART D CREDITABLE COVERAGE NOTICE

Medicare-Eligible Participants: Important Notice About Your Prescription Drug Coverage and Medicare

This is a legally required notice that PG&E must provide annually to all employees, retirees and surviving dependents eligible for PG&E-sponsored medical coverage. Please read this notice and keep it where you can find it. No other action is required.

This notice has information about your current prescription drug coverage under plans sponsored by Pacific Gas and Electric Company (PG&E) and your options under Medicare's prescription drug coverage (called Part D). This information can help you decide if you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. PG&E has determined that the prescription drug coverage offered by the Pacific Gas and Electric Company Health Care Plan for Active Employees and by the Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and therefore is considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you enroll in a Medicare drug plan?

You can enroll in a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you decide to drop your PG&E-sponsored coverage or if you lose your current creditable prescription drug coverage through no fault of your own, you also will be eligible for a two-month Special Enrollment Period (SEP) to enroll in a Medicare drug plan.

What will happen to your current medical coverage if you decide to enroll in a Medicare drug plan?

Prescription drug coverage is included in all PG&E-sponsored medical plans. Every medical plan that PG&E currently offers to Medicare-eligible participants has a higher prescription drug benefit than the basic Medicare Part D benefit.

If you decide to enroll in a Medicare drug plan that is not sponsored by PG&E (in other words, a plan not offered by PG&E during the enrollment period), **your PG&E-sponsored medical and prescription drug benefits will be terminated.**

Can you re-enroll in a PG&E-sponsored medical plan at a later date?

Eligible retirees, employees on Long-Term Disability and dependents who enroll in a non-PG&E Medicare drug plan will not be able to re-enroll in a PG&E-sponsored medical plan until the next Open Enrollment. If you're an eligible retiree and you want to initiate re-enrollment, you must call the HR Service Center to request an Open Enrollment packet no later than September 1 to elect coverage effective the following January 1.

Surviving dependents who enroll in a non-PG&E Medicare drug plan will not be able to re-enroll in a PG&E-sponsored plan at any time.

PG&E-sponsored medical plans with prescription drug coverage and Medicare Advantage Plans are available during Open Enrollment for eligible retirees, surviving dependents and employees on Long-Term Disability.

KEEP THIS CREDITABLE COVERAGE NOTICE

This is a legally required notice about your benefits. Please read this notice carefully and keep it where you can find it.

If you decide to enroll in a Medicare drug plan, you may be required to provide a copy of this notice when you enroll to show that you have maintained creditable coverage. If you have maintained creditable coverage, you will not be required to pay a higher premium (a penalty).

When will you pay a higher premium (penalty) to enroll in a Medicare drug plan?

If you drop or lose your current PG&E coverage and you don't enroll in a Medicare drug plan within 63 continuous days after your PG&E-sponsored coverage ends, you may have to pay a higher premium (a penalty) to later enroll in a Medicare drug plan.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least one percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

Where can you find more information about PG&E-sponsored coverage?

For more information about this notice or your current PG&E-sponsored prescription drug coverage, contact the HR Service Center. NOTE: You'll get this notice each year before the next period you can enroll in a Medicare drug plan. You'll also get this notice if PG&E sponsored prescription drug coverage changes. You may request a copy of this notice at any time.

Where can you find more information about your options for Medicare prescription drug coverage?

Detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You also may be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- For personalized help, call your state Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for their telephone number).
- Call **800-633-4227 (800-MEDICARE)**. TTY users should call **877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit www.socialsecurity.gov or call **800-772-1213 (TTY 800-325-0778)**.

October 2011
Pacific Gas and Electric Company

HR Service Center
1850 Gateway Boulevard, 7th floor
Concord, CA 94520

Remember, keep this creditable coverage notice.

You will need it if you decide to enroll in a Medicare drug plan and want to avoid paying a higher premium (a penalty) for lack of creditable coverage.

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 2012 enrollment material, including your Enrollment Worksheet, *Benefits 2012* brochure, the 2012 *Legal Supplement* and your confirmation statement;
- Acknowledge that you have received the “Notice about Your Prescription Drug Coverage and Medicare” included in the 2012 *Legal Supplement*;
- For retirees, surviving dependents and individuals on Long-Term Disability (LTD), you acknowledge that you understand your PG&E medical and prescription drug coverage will be cancelled if you enroll in a Medicare Part D Prescription Drug Plan or Medicare Advantage Plan outside of the PG&E enrollment process;
- Agree to provide Pacific Gas and Electric Company or any Participating Employers with Social Security numbers and Medicare Claim Numbers, if applicable, for you and your dependents, and authorize Pacific Gas and Electric Company and any Participating Employers to release Social Security numbers and Medicare Claim Numbers for you and your dependents to governmental agencies, third-party administrators and insurers, as required, for purposes of plan administration;
- Authorize the Participating Employer to deduct any required before-tax or after-tax contributions from your pay, pension check or LTD benefits, or to bill you for any contributions you owe if your pension check or LTD benefits are insufficient;
- Acknowledge that the Health Savings Account is not an ERISA benefit or plan and that you are fully responsible for all investment decisions relating to funds held in any such account;
- Acknowledge that unless you experience an eligible change-in-status event, you will not be able to change medical plans during 2012 (a change-in-status event does not occur 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);
- For active employees, you acknowledge that any current HCRA/DCRA and Vacation Buy Day elections cannot automatically roll forward into 2012 and that you must actively re-enroll to make new HCRA, DCRA and Vacation Buy Day elections for 2012;
- Agree to reimburse the Participating Employer for the value of any Vacation Buy Days taken but not paid for, should you terminate employment or transfer to a union-represented position during 2012;
- Acknowledge that PG&E, the other Participating Employers and the health plan administrators and 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; and
- Agree to call the HR Service Center to report any ineligible dependents within 31 days of a dependent’s loss of eligibility.

PG&E HR SERVICE CENTER

Active employees and employees on leave or Long-Term Disability

Phone:
415-973-4357 or 800-788-2363
E-mail:
hrbenefitsquestions@exchange.pge.com

Retirees and surviving dependents

Phone:
415-972-7077 or 800-700-0057
E-mail:
hrbenefitsquestions@exchange.pge.com

Representatives are available Monday through Friday from 7:30 a.m. to 5 p.m. Pacific Time.

Summary of Material Modifications (October 2011)

The *Benefits 2012* brochure and the 2012 *Legal Supplement* constitute a Summary of Material Modifications to the PG&E Health Care Plans.

The *Benefits 2012* brochure for Management and Administrative & Technical Employees; the *Benefits 2012* brochure for Employees Represented by the IBEW, ESC and SEIU; the *Benefits 2012* brochure for Employees on Long-Term Disability; the *Benefits 2012* brochure for Retirees and Surviving Dependents; and the 2012 *Legal Supplement* (referred to collectively as your "enrollment materials") are designed, in part, to: (1) make you aware of important changes that have been made to The Pacific Gas and Electric Company Health Care Plan for Active Employees and The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents (the "Health Care Plans"); (2) provide you with answers to some common questions that arise in connection with enrollment in the Health Care Plans; and (3) provide you with some important information about your rights under the Health Care Plans. Your 2012 enrollment materials are not an exhaustive explanation of the Health Care Plans. Additional information about the Health Care Plans is contained in the documents entitled *The Pacific Gas and Electric Company Health Care Plan for Active Employees*, *The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents*, the *Summary of Benefits Handbook* and the Summaries of Material Modifications, including enrollment brochures designated as Summaries of Material Modifications, as well as the Evidence of Coverage booklets issued by the health maintenance organizations (HMOs). Together, these documents collectively constitute the official plan document.

The Employee Benefits Committee of PG&E Corporation is the Plan Administrator of the Health Care Plans 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 that comprise the official plan documents, and to establish rules that are necessary for the administration of the Health Care Plans.

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

