Welcome!

This is the 2026 edition of your Summary of Benefits Handbook, which describes your benefits effective January 1, 2026.

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

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation.

- The *Health Account Plan (HAP)* (including prescription drug and mental health and substance use disorder benefits), dental and vision coverage, the Employee Assistance Program, and the Wellness Program.
- *Flexible Spending Accounts (FSAs)* that can help you pay for certain health care and dependent care expenses on a before-tax basis. PG&E offers two FSAs — the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account.
- A *Health Account* will also be established for those enrolled in the Health Account Plan (HAP).
- *Time Off and Leaves* including vacation days, company-paid holidays, floating holidays, sick leave (for IBEW- and SEIU-represented employees) and incidental sick time (for ESC-represented employees), and leaves of absence, paid or unpaid.
- A *Short-Term Disability (STD) Policy* for ESC-Represented Employees.
- A *Long-Term Disability (LTD) Plan*.
- *Life and Accident Insurance Plans*, including *Business Travel Insurance (BTI)*.
- *Retirement Benefits*, including the Pacific Gas and Electric Company Retirement Plan and the Retirement Savings Plan (RSP) for Union-Represented Employees.
- *Work/Life Benefits*, such as Adoption Assistance, the Commuter Transit Program, the Tuition Refund Program, discounts on gas and electric services for your home, as well as other Company-negotiated discounts.

This Handbook Is for Union-Represented Employees

- This Handbook describes benefits available to eligible union-represented employees.
- This Handbook does not address benefits for Management or Administrative & Technical employees. If you are a Management or Administrative & Technical employee, you should refer to the Summary of Benefits Handbook for Eligible Management, Administrative and Technical Employees for information regarding available benefits.
- This Handbook does not address benefits for Hiring Hall employees. If you are a Hiring Hall employee, you should refer to the *Summary of Benefits Handbook for Hiring Hall Employees* for information regarding available benefits.

The Benefits Available

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

plan sections in this Handbook as well as the *Health Care Participation* section for health care plan eligibility and enrollment information.

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

Questions?

If you have any questions about your benefits that are not answered by this Handbook or other benefit plan documents, you can contact the PG&E Benefits Service Center at **1-866-271-8144**. You can also send a secure email message or initiate a chat session with a Benefits Representative by logging onto PG&E's Benefits Portal* (accessible through PG&E@Work For Me or mypgebenefits.com), or contact your union Business Representative or the Local Union headquarters.

*For the purposes of this SPD, "PG&E's Benefits Portal" refers to myPlans Connect.

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About this Handbook

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

Plan Documents Govern

The plan document for each plan described in this Handbook incorporates the terms of this Summary of Benefits Handbook that pertain to the plan as well as any applicable Summaries of Material Modifications.

Unless otherwise noted, if there is a conflict between the plan document and this Summary of Benefits Handbook, the plan document controls. If the plan document is silent on a specific issue, then this Summary of Benefits Handbook controls on that issue.

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

Plan Amendment and Termination

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

Any change to the plans or the termination of any plans will not affect the benefits payable to plan members (also known as “participants”) before the date the plan was changed or ended, but such change may result in reduced levels of benefits or benefit coverage, or higher levels of employee contributions, after the effective date of any such change.

The plans may also be terminated by judicial action if the Company is bankrupt or insolvent, or upon complete dissolution, merger, consolidation or reorganization without provision by a successor-company for continuation of the plans.

Eligibility and Enrollment

New Hire Eligibility and Enrollment

Eligibility

If you are a full-time or part-time employee represented by the IBEW, ESC, or SEIU, regardless of whether you are an intermittent employee, a probationary employee, a casual employee, or have reached regular status, or are an employee on Long-Term Disability (LTD):

- You are generally eligible to participate in the benefits described in this Handbook.
- You are generally immediately eligible to enroll in health care coverage (medical, dental and vision).
- Unless you are on LTD, you are generally immediately eligible to enroll in the Flexible Spending Accounts.
- You are automatically eligible to receive benefits from the Employee Assistance Program (EAP).
- You are eligible to participate in the Retirement Plan and the Retirement Savings Plan (RSP) for Union-Represented Employees.
- You'll become eligible for life insurance after completing six months of service and attaining regular status.
- Notwithstanding the foregoing, some benefits described in this Handbook may be conditioned on status as a regular employee. In order to determine your eligibility for a particular benefit, refer to the discussion of that benefit in this Handbook.
- See *Health Care Participation* for information on your dependents' eligibility to participate in the health care plans (medical, dental and vision).

If you are a temporary additional employee, an outage employee, a probationary intermittent employee, an employee excluded under a union agreement, a contract or agency employee, an intern, a summer hire, or a retiree of the Company (unless you have been rehired and you are actively working in an eligible union-represented position):

- You are generally not eligible to participate in the benefits described in this Handbook.
- Notwithstanding the foregoing, you may be eligible to participate in PG&E's Voluntary Disability and Paid Family Leave Plan and certain state-mandated leave entitlements. See the *Sick and Disability* section for more details.

This Handbook does not address benefits for Management or Administrative & Technical employees. If you are a Management or Administrative & Technical employee, you should refer to the Summary of Benefits Handbook for Eligible Management, Administrative and Technical Employees for information regarding available benefits.

This Handbook does not address benefits for Hiring Hall employees. If you are a Hiring Hall employee, you should refer to the Summary of Benefits Handbook for Hiring Hall Employees for information regarding available benefits.

New Hire Enrollment

If you are eligible, you must enroll in PG&E-sponsored health care coverage (medical, dental and vision) within 31 days of your hire date. Otherwise, your next chance to enroll will be the next fall during Open Enrollment or if you have an eligible mid-year election change event. If you do not enroll in your health coverage within the time requirements, you will receive default coverage. In that case, unless you have an eligible mid-year change event, you will not be able to change from default coverage until the next Open Enrollment.

31-Day Deadline!

Enroll online or by phone within 31 days of your hire date. If you're late, your elections won't be accepted, and you'll have no PG&E-sponsored health coverage.

Shortly after you are hired, you will receive a New Hire email or letter from the PG&E Benefits Service Center containing instructions on how to enroll in your employee benefit options.

You're covered by the Retirement Plan immediately upon hire. There's no need to enroll — coverage is automatic. You'll also receive enrollment information separately for the Retirement Savings Plan (RSP), mailed to your home from Fidelity Investments within two weeks of your hire date. If you haven't enrolled to make a 401(k) contribution within 30 days of your hire date, you'll be automatically enrolled at an 8% contribution level.

You are automatically covered under PG&E's Voluntary Disability and Paid Family Leave Benefit Plan (Voluntary Plan) unless you opt out of coverage within the first 31 days of hire. If you choose to opt out of the Voluntary Plan, you will be enrolled in the State Disability and Paid Family Leave Plan in accordance with California law. See the *Sick and Disability* section for more details.

Your medical, dental, and vision benefits, and any elected contributions to a Health Care or Dependent Care Flexible Spending Account, will go into effect on your first day of employment at PG&E, provided you enroll within 31 days of your hire date.

Upon completing six months of continuous service and attaining regular status, you will receive enrollment information for group life insurance. Your benefits will go into effect on the first day of the month following the Company's receipt of your request to enroll, provided your request is received within 90 days of the date on which you became eligible for group life insurance.

You can elect life insurance up to six times your annual pay without evidence of good health, provided that you make such election within 90 days of initial eligibility.

If elected within 90 days of eligibility, dependent life insurance coverage up to $25,000 will be automatically approved for your spouse or registered domestic partner. After 90 days, evidence of good health is required for any coverage request for the same spouse/domestic partner.

You will be automatically enrolled in the RSP as of the first pay period that starts 30 days after your hire date, or as soon thereafter as practicable.

Enrolling in Health and Welfare Benefit Coverage

You will receive communication from the PG&E Benefits Service Center via US Mail regarding your new hire enrollment. You do not need to wait for that communication. You may log in to PG&E's Benefits Portal or call the PG&E Benefits Service Center approximately one week after beginning employment to make your benefit elections. Review the options available to you and make your selections within 31 days of hire to avoid being assigned default coverage. Detailed information about each benefit plan is contained in this Summary of Benefits Handbook and in the annual Benefits Enrollment Guides.

After you have reviewed your plan options, complete your enrollment online on PG&E's Benefits Portal or by calling the PG&E Benefits Service Center within 31 days (see below).

Enroll Yourself and Your Eligible Dependent(s) Within 31 Days Of Hire

Enroll online on PG&E's Benefits Portal, or call the PG&E Benefits Service Center at 1-866-271-8144.

- You may access PG&E's Benefits Portal by visiting PG&E@Work For Me > About Me > My Benefits > myPlans Connect. You'll automatically be logged in to your account.
- If you access PG&E's Benefits Portal via mypgebenefits.com, you'll need to register first by creating a User ID and password.
- Regardless of how you enroll, you'll receive a confirmation statement within 10 business days of the date on which you enroll.
- If you do not enroll or decline coverage within the time requirements, you will be automatically assigned default coverage as described under "Default Coverage" below.

If you have any questions about enrolling in your benefits, you can send a secure email or initiate a chat session on PG&E's Benefits Portal (accessible through PG&E@Work For Me or mypgebenefits.com), or call the PG&E Benefits Service Center at 1-866-271-8144.

Declining Health and Welfare Benefit Coverage

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

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

About Declining Coverage

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

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

If you have any questions about declining medical, dental and/or vision coverage, you can log on to PG&E's Benefits Portal (accessible on PG&E@Work For Me or mypgebenefits.com) and send a secure email or initiate a chat session with a Benefits Representative, or you can contact the PG&E Benefits Service Center at **1-866-271-8144**.

Default Coverage

If You Do Not Enroll in, or Decline, Coverage Upon Hire: Default Coverage

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

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

Once effective, your default coverage will remain in effect for the entire calendar year. You may not make changes to your coverage until the next Open Enrollment period, unless you have an eligible mid-year change event, as described in "Mid-Year Election Change Events".

Take Action with Regard to the RSP

You'll receive an enrollment kit from Fidelity, the RSP administrator, within two weeks of your hire date. You may begin contributing to the Plan at any time, and you'll receive PG&E matching contributions as soon as you begin contributing. You can enroll online at Fidelity NetBenefits (401k.com) or at 1-877-743-4015.

If you are automatically enrolled in the RSP, you should review your plan contributions and investments to confirm that the default elections are appropriate for you. You can make changes through Fidelity NetBenefits online account services at 401k.com or by contacting Fidelity at 1-877-743-4015.

Review Your Confirmation Statement

Report any errors on your Confirmation Statement by contacting the PG&E Benefits Service Center within 10 business days of the date on which you receive your confirmation statement.

If any of your information appears to be incorrect, you can send a secure email or initiate a chat session on PG&E's Benefits Portal, or call the PG&E Benefits Service Center at 1-866-271-8144.

Open Enrollment

Each year, you have an opportunity to change your health care coverage elections for the coming calendar year during the Open Enrollment period. The Open Enrollment period typically occurs in the fall. The cost for each benefit option will be included in your Open Enrollment materials.

The elections you make during Open Enrollment take effect on January 1 of the next year and remain in effect for the entire year. You may not make changes to your coverage until the next Open Enrollment period, unless you have an eligible mid-year change event, as described under "Mid-Year Election Change Events."

Enrolling in Health and Welfare Benefit Coverage

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

During Open Enrollment, you may add eligible dependents or delete dependents from your coverage. Please see *Health Care Participation* for information on your dependents' eligibility to participate in the health care plans (medical, dental and vision).

Note that ineligible dependents must be deleted promptly and, in any event, within 31 days of the time when they lose eligibility.

Declining Health and Welfare Benefit Coverage

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

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

About Declining Coverage

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

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

If you have any questions about declining medical, dental and/or vision coverage, you can log on to PG&E's Benefits Portal (accessible on PG&E@Work For Me or mypgebenefits.com) and send a secure email or initiate a

chat session with a Benefits Representative, or you can contact the PG&E Benefits Service Center at **1-866-271-8144**.

Default Coverage

If You Do Not Enroll in, or Decline, Coverage at Open Enrollment: Default Coverage

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

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

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

For information on Life and Accident insurance enrollment, see "Changing the Level of Your Coverage."

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

Mid-Year Election Change Events

Change-in-Status Events

You may change certain elections mid-year if you experience a change-in-status event listed below. You must notify the Company as provided in "Don't Miss the Deadlines!" section below within 31 days after the occurrence of the event causing the change (180 days for births, adoptions, and placements for adoption) in order to make a change in your election during the year. **Where applicable, the changes you make to your coverage must be consistent with and "on account of and correspond with" the event.** For example, if your child no longer is eligible for medical benefits, you may cancel medical coverage only for that child, not yourself or your spouse.

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment. (Please note that you cannot enroll your ex-spouse on your Company-sponsored health care plans even if a court orders you to provide coverage.)
- **Change in domestic partnership status:** Commencement or dissolution of a domestic partnership. (Please note that you cannot enroll your former registered domestic partner on your Company-sponsored health care plans even if a court orders you to provide coverage.)
- **Number of eligible dependents:** Any event that changes your number of eligible dependents including birth, death, adoption, legal guardianship, and placement for adoption.
- **Employment status:** Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage.
- **Dependent Status:** Any event that causes your eligible dependents to become eligible or ineligible for coverage because of age, disability, or similar circumstances.

- **Residence:** A change in the place of residence for you or your eligible dependents if the change results in you or your eligible dependents living outside the network service area of your medical coverage.

Your coverage will be effective on the first day of the month following notification of your change-in-status event, except in the case of birth, adoption, or placement for adoption (in which case the change will be effective on the date of the event).

HIPAA Special Enrollment Events

If you decline enrollment for medical benefits for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the Company-sponsored medical benefits mid-year if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your eligible dependents' other coverage). However, you must request enrollment within 31 days after your eligible dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll both yourself and any eligible dependents within 31 days after the marriage or within 180 days after the birth, adoption, or placement for adoption.

You also may enroll in medical benefits mid-year if you or your eligible dependents no longer are eligible for Medicaid or a state Children's Health Insurance Program (CHIP) coverage, or if you or your eligible dependents become eligible for a state's premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event.

Your coverage will be effective on the first day of the month following notification of your HIPAA special enrollment event, except in the case of birth, adoption, or placement for adoption (in which case the change will be effective on the date of the event).

Other Mid-Year Election Change Events

In addition, you may change your election mid-year if you experience a change listed below. You must notify the Employer within 31 days after the occurrence of the event causing the change in order to make a change in your election during the year.

- **Entitlement to Medicare or Medicaid:** If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid.
- **Judgment, Decree, or Order:** If a judgment, decree or order, such as a QMCSO, requires your dependent child to be covered under this Plan (or another plan).
- **Significant Change in Coverage:** If the cost of coverage is significantly increased or decreased, or if benefits are significantly improved or curtailed.

Your coverage will be effective as of the date enrolled, except for a judgment, decree, or order, in which case coverage is effective on the date the Plan processes the judgment, decree, or order.

Don't Miss the Deadlines!

Call the PG&E Benefits Service Center or report the change on PG&E's Benefits Portal (accessible through PG&E@Work For Me or mypgebenefits.com) under "Life Events" within 31 days of any eligible mid-year election change event (60 days for loss of Medicaid/CHIP or becoming eligible for a premium assistance subsidy and 180 days for birth, adoption, or placement for adoption) that may affect your benefits. Written documentation may be requested. After these deadlines, you will not be able to make any change until the next Open Enrollment period unless you experience another mid-year election change event.

Health Care Benefits

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

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation.

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

- *Health Care Participation*
- *Medical Coverage for Active Employees*
  - *The Health Account Plan (HAP)*
- *Medical Coverage for Participants on Long-Term Disability*
  - "Anthem Network Access Plan (NAP)"
  - "Anthem Comprehensive Access Plan (CAP)"
  - "Kaiser Exclusive Provider Organization (EPO) Plan"
  - "Kaiser Senior Advantage Plan"
- *Glossary*
- *Wellness Program*
- *Employee Assistance Program (EAP)*
- *Dental Coverage*
- *Vision Coverage*

Additional Information

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

Responsibility for Your Health Care

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

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

Plan Documents and Administration

The plan document for The Pacific Gas and Electric Health Care Plan for Active Employees incorporates the terms of this Summary of Benefits Handbook that pertain to the plan as well as any applicable Summaries of Material Modifications and insurance policies.

Unless otherwise noted, if there is a conflict between the plan document and this Summary of Benefits Handbook, the plan document controls. If the plan document is silent on a specific issue, then this Summary of Benefits Handbook controls on that issue. However, with respect to fully insured benefits, the terms of the certificate of insurance or other similar document control when describing specific benefits that are covered or insurance-related terms.

The Employee Benefit Committee of PG&E Corporation has the discretionary authority to interpret and construe the terms of the plan, to resolve any conflicts or discrepancies between documents and to establish rules which are necessary or desirable for the administration of the plan. Notwithstanding the foregoing, the relevant insurer has the authority to construe and interpret the terms of the certificate of insurance or other similar document.

Health Care Participation

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Eligible Employees

You are eligible to enroll for health care coverage (medical, dental and vision), and you're automatically eligible to receive benefits from the Employee Assistance Program (EAP) if you are a full-time or part-time employee represented by the IBEW, ESC, or SEIU, regardless of whether you are an intermittent employee, a probationary employee, a casual employee, or have reached regular status, or are an employee on Long-Term Disability (LTD).

If you're a former PG&E retiree and return to PG&E as a regular employee and enroll for employee health coverage, your PG&E-sponsored retiree medical coverage will end on the last day of the month in which you become a regular employee. If you have a Retiree Health Account, it will be suspended until you go back to retiree status.

If you're a former Hiring Hall employee and return to PG&E as a regular employee and enroll for employee health coverage, your employee coverage will start on the first of the month following the date you become a regular employee—even if you waived Hiring Hall medical coverage. This means you could have a period of time without

coverage after you become a regular employee. If you have Hiring Hall medical coverage when you become a regular PG&E employee, your Hiring Hall coverage will end on the last day of the month in which you become a regular employee—even if you waive employee coverage.

LTD employees are eligible for different medical plans than active employees. For employees who are newly approved for LTD, you and your enrolled family members will be automatically switched to an LTD medical plan effective the first of the month following your LTD approval date. See *Medical Coverage for Participants on Long-Term Disability*.

You are not eligible to enroll for active employee health care coverage, or receive benefits from the EAP, if you are a temporary additional employee, an outage employee, a probationary intermittent employee, an employee excluded under a union agreement, a contract or agency employee, an intern, a summer hire, or a retiree of the Company (unless you have been rehired and you are actively working in an eligible union-represented position).

Eligible Dependents

You may also enroll your eligible dependents in the health care plans. Eligible dependents include:

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

Employee/Retiree Couples

If you and your family member or registered domestic partner are both union-represented employees or are retirees, you each have the option of being covered as an "employee" or "retiree," or you can be covered as a "dependent" of the other. However, you may not be covered as both, nor may you be covered as both an employee and a retiree. Active union-represented employees may, however, cover family members who are PG&E retirees or Hiring Hall employees.

Spouses and Registered Domestic Partners

Spouses

Spouses of eligible employees are eligible for coverage under the Company's medical, dental and vision care plans. Your spouse is the individual to whom you are lawfully married and from whom you are not legally separated. Under the regulations, a marriage of two individuals will be recognized for federal tax purposes if the marriage is recognized by the state, possession, or territory of the United States in which the marriage takes place, regardless of the married couple's place of domicile. For foreign marriages, two individuals who enter into a relationship that is denominated as marriage under the laws of a foreign jurisdiction will be recognized as being married for federal tax purposes if the relationship would be recognized as marriage under the laws of at least

one state, possession, or territory of the United States, regardless of domicile. Your spouse includes your legally state-recognized common-law spouse.

Registered Domestic Partners

Registered domestic partners of eligible employees are eligible for coverage under the Company's medical, dental and vision care plans. To be eligible for domestic partner health benefits, the domestic partnership must be registered with a government entity (e.g., the City and County of San Francisco), pursuant to state or local law authorizing such registration.

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

Federal Taxes

The value of health coverage for your registered domestic partner and their children will be treated as income to you for federal income tax purposes. This is called imputed income.

Imputed income is based on a formula that includes the fair market value of your health coverage. It's not simply how much you and PG&E pay for coverage.

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 amount of imputed income taxable to you can be substantial, and will vary depending on the health coverage you elect and the number of dependents you cover. Please contact your tax advisor or call the PG&E Benefits Service Center for more information.

California Taxes

For California income tax purposes, the value of the health coverage 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 or call the PG&E Benefits Service Center for more information.

Certifying Your Domestic Partner and Their Children as Tax Dependents

An exception to the imputed income reporting and withholding rules applies if your registered domestic partner or children of your registered domestic partner are your tax dependents under Internal Revenue Code section 105(b). Many registered domestic partners do not qualify as tax dependents. However, if your domestic partner or their children are your eligible tax dependents, you'll need to certify them as such by calling the PG&E Benefits Service Center within 31 days of the date your domestic partnership is notarized or filed.

If you complete the certification, the value of their health benefits will not be reported as taxable income. Your dependents' tax certified status will remain in place until you notify the PG&E Benefits Service Center of a change.

Registered Domestic Partner Dependents

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

Disabled Dependents

You can arrange for coverage to continue past the customary age limits for a child who is incapable of self-support because of a physical or mental disability, as certified by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), provided the child's disability began and was certified through the PG&E Disabled Dependent

process before he or she became otherwise ineligible for coverage. Your child must depend chiefly on you for support in order to qualify for the continued coverage and must also meet the definition of an Eligible Dependent.

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

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

Ineligible Dependents

Ineligible dependents include, but are not limited to:

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

Dependents of Employee/Retiree Couples

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

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

If you have any questions about whether or not a dependent is eligible for coverage, you can contact the PG&E Benefits Service Center at **1-866-271-8144**. You can also access your benefits information on PG&E's Benefits Portal from your computer or mobile device at mypgebenefits.com.

If you cover an ineligible dependent, you'll be required to pay restitution for the costs of providing health care coverage to the ineligible dependent—up to two full years of the cost of coverage. Knowingly covering an ineligible dependent is considered fraud, and can be grounds for termination of employment.

To drop ineligible dependents, call the PG&E Benefits Service Center or log on to PG&E's Benefits Portal.

Providing dependent verification

If you're enrolling online, an alert in the Benefits Portal will tell you that a dependent needs to be verified. Once you click the notification you'll be able to see:

- Which dependent needs verification
- What documents you need to submit

You can upload, mail or fax the required documents.

If you're enrolling by phone, the PG&E Benefits Service Center representative will help you with the verification process.

IMPORTANT: PG&E reserves the right to request documentation of your dependents' eligibility at any time. Please note that knowingly covering an Ineligible Dependent is considered fraud, and can be grounds for termination of employment.

Qualified Medical Child Support Orders (QMCSOs)

In accordance with federal law, the Plan will extend benefits to your non-custodial child, as required by a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order giving a child who otherwise might not be eligible for medical coverage under the Plan a right to such coverage. In addition, a properly completed National Medical Support Notice issued by a State child support enforcement agency must be treated as a QMSCO. The Company will determine if a court order or a National Medical Support Notice satisfies the legal requirements to be treated as a QMCSO in accordance with the written procedures established under the Plan. You may request a copy of the procedures, free of charge, by contacting the PG&E Benefits Service Center at **1-866-271-8144**.

You will be notified of the receipt of an order or National Medical Support Notice affecting your children and the Company's procedures and determination with respect to the order. If the Company determines that the order or National Medical Support Notice is a QMCSO, then the Company will enroll the child pursuant to the court order and deduct any required contributions, even without your direct consent. If you are not already enrolled, you must elect to participate at the time you are required to provide coverage for your child(ren). If you are enrolled in a health care program that will not cover dependent children who do not reside with you, you may change to a program for which you are eligible that will cover your children. If you do not voluntarily change, the Company will enroll you in the Health Account Plan (HAP) administered by Anthem Blue Cross and will deduct the required monthly contributions associated with the coverage under the HAP.

If Eligibility Is Denied

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

If you are not satisfied with the outcome of your contact with the PG&E Benefits Service Center, you may file an eligibility claim by writing to:

Pacific Gas and Electric Company
Benefits Department
Health Plan Claims
300 Lakeside Drive
Oakland, CA 94612

PG&E reserves the right to request documentation of your dependents' eligibility at any time. Please note that knowingly covering an Ineligible Dependent is considered fraud, and can be grounds for termination of employment.

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

Eligibility Appeals

If you are not satisfied with the Benefit Department's decision on your claim, you may then submit a written appeal for review (within 60 days of receiving the Benefits Department's notice of denial) to the Employee Benefit Appeals Committee (EBAC), the final decision maker in the appeals process, stating the reasons for your appeal and enclosing all documentation and any additional information to support your appeal.

No special form or format is required in submitting a written appeal; you may submit written comments, documents, records, and other information relating to your appeal. You may also request, free of charge, access to, or copies of, all documents, records, and other information relevant to your appeal for benefits. The review will take into account all comments, documents, records, and other information submitted by you relating to your appeal, without regard to whether such information was submitted or considered at the initial benefit determination.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department – EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

You will receive a final ruling from the EBAC within 60 days of the EBAC's receipt of your appeal unless, due to special circumstances, the EBAC requires additional time to respond, up to another 60 days.

Cost of Coverage

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

Contributions for Full-Time Employees

Full-time union-represented employees pay approximately 7.5% of the actual premium for the medical plan they select. Per the 2019 Bargaining Agreement, employee contribution rates are frozen at the medical plan rates as of 2019 through 2025. Your contributions for the medical plan you choose (if any) will be deducted from your second paycheck of each month on a before-tax basis. Full-time employees are not required to contribute toward the cost of their dental and vision premiums.

Contributions for Part-Time Employees

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

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

The amount the Company contributes is based on the ratio of actual straight-time hours worked for the 12-month period (from October 1 of the previous year to September 30 of the current year) to the full-time hourly equivalent of 2,080 hours. The Company will contribute an amount equal to this percentage multiplied by the cost of the Anthem Blue Cross HAP plan. The cost of coverage for part-time new hires will be based on an assumed schedule of 36 hours of work for their first six months of employment. When the part-time employee completes six months of service, the cost of coverage will be recalculated, based on their scheduled number of straight-time hours.

For regular-status employees who became part-time employees prior to January 1, 1991, no contribution is required for dental or vision coverage. For regular-status employees who became part-time employees January 1,

1991, or later, dental and vision contributions are required. The amount the Company contributes is based on the ratio of actual straight-time hours worked for the 12-month period (from October 1 of the previous year to September 30 of the current year) to the full-time hourly equivalent of 2,080 hours. The Company will contribute an amount equal to this percentage, multiplied by the cost of the coverage for the dental and vision plans. The cost of coverage for part-time new hires will be based on an assumed schedule of 36 hours of work for their first six months of employment. When the part-time employee completes six months of service, the cost of coverage will be recalculated, based on the scheduled number of straight-time hours.

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

Contributions for Employees on Leaves of Absence

Employees on leaves of absence are also required to pay medical plan contributions. Depending on the type of leave you are on and how long you have been on leave, your leave of absence package will explain your medical plan premiums and payment options while on leave.

Contributions for Employees on Long-Term Disability

Employees on Long-Term Disability (LTD) will be required to pay the same premium cost as active employees for medical coverage. Medical contribution deductions will be taken on a before-tax basis from the employee's Long-Term Disability check, provided the employee is receiving LTD payments. Employees on LTD are not required to contribute toward the cost of dental and vision coverage.

Medicare Part B Credit for LTD Employees and Dependents on Medicare

In accordance with plan rules, LTD employees and/or their covered family members who are eligible for Medicare *must be* enrolled in Medicare Part B while on LTD, since PG&E's LTD plans only pay on a secondary basis after Medicare. To offset the cost of the monthly premiums you pay to the Social Security Administration for Part B coverage, the Company provides you and any under-age-65 Medicare-eligible dependents a monthly Medicare Part B Refund credit that is equal to the standard Part B premium amount. For Medicare-eligible family members who are age 65 or older, the Company will provide a Medicare Part B refund credit of $15 per month. The Medicare Part B Refund credit will show as an after-tax line item on your monthly LTD check and will be deducted from your LTD medical plan premium. For example, if you and your spouse are both under age 65 but receiving Social Security Disability benefits because you have both been disabled more than two years, you will receive two Medicare Part B Refund credits on your monthly LTD check. You must be a participant in a PG&E-sponsored medical plan and enrolled in Medicare Part B to qualify for the credit. See "Coordination with Medicare" for more details.

If You Have Other Coverage

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

Anthem Blue Cross Plans. If you are enrolled in a plan administered by Anthem Blue Cross (Anthem HAP or the LTD NAP/CAP), Anthem Blue Cross will coordinate benefits with any other group health plans for which you are eligible. This means your Anthem plan will pay benefits on a secondary basis if any of your enrolled dependents have primary medical coverage elsewhere. Be sure to contact Anthem Blue Cross to determine if and when it will coordinate benefits on a secondary basis. In addition, if you are on Long-Term Disability (LTD) and you and any family members are enrolled in the LTD CAP with Medicare, Anthem will automatically coordinate your benefits with Medicare Parts A and B; make sure all Medicare-eligible family members are enrolled in Part B.

Kaiser HAP. The Kaiser HAP does not coordinate with any other Kaiser Permanente plan. If you or your dependents have coverage under the PG&E Kaiser HAP and you also have coverage under another Kaiser Permanente plan through your spouse or parents, no additional benefits will be paid once Kaiser has paid benefits under the plan that is primary. There is no advantage to having dual coverage with Kaiser if you are enrolled in the Kaiser HAP. In addition, if you have double coverage with a non-Kaiser plan, your Kaiser HAP will

not pay benefits on a secondary basis if you use non-Kaiser network providers. (There are limited exceptions in which Kaiser may coordinate benefits with another non-Kaiser plan — for example, when Kaiser refers you to a non-network provider for specialized treatment which cannot be provided by Kaiser providers. Contact Kaiser Permanente for more information.)

Kaiser EPO Plan. For employees on Long-Term Disability (LTD) and/or their family members who are enrolled in the Kaiser EPO Plan, Kaiser will assume that the EPO Plan is primary if the claim indicates you have no other coverage. If Kaiser has conflicting information about potential other coverage, claims will be "soft denied," and Kaiser will follow prescribed investigation procedures to determine if you or a family member has other coverage.

Kaiser Permanente Senior Advantage (KPSA): For employees on Long-Term Disability (LTD) and/or their family members who are enrolled in Kaiser Senior Advantage North or South, your Medicare benefits must be assigned to the Kaiser Senior Advantage Plan, so your Senior Advantage benefits will automatically be coordinated with Medicare by Kaiser Permanente.

Combined payments from all plans will not exceed 100% of the allowable expense for covered services. Mental Health and Substance Use Disorder benefits are administered by Carelon Behavioral Health and are subject to the terms of that program.

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

Here's how coordination of benefits works:

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

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

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

Which Plan Is Primary for You?

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

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

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

Which Plan Is Primary for Your Children?

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

- A plan without a coordination of benefits provision will pay benefits before a plan with such a provision.

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

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

Coordination with Medicare

Medicare Parts A and B

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

- **For individuals who are entitled to Medicare due to End Stage Renal Disease (ESRD)**, your Company-sponsored medical plan will pay benefits before Medicare for the first 30 months of Medicare eligibility or entitlement. After 30 months, Medicare Part A and Part B will become the primary payer and the Company-sponsored plan will become the secondary payer. Please notify Anthem Blue Cross or Kaiser Permanente as soon as ESRD is diagnosed.
- **For individuals on Long-Term Disability (LTD) who are entitled to Medicare due to disability**, and also for any Medicare-eligible dependents they cover, Medicare Parts A and B will become primary payers and the Company-sponsored plan will become the secondary payer. (Note: LTD recipients are not eligible for coverage in the Health Account Plan (HAP), and must switch to one of the PG&E-sponsored medical plans offered to employees on LTD. Available medical plan options are described in *Medical Coverage for Participants on Long-Term Disability*.)

This means that all active employees enrolled in the Health Account Plan (HAP), except those as qualified above, should submit claims first to Anthem Blue Cross or Kaiser Permanente. In addition, all employees who are eligible for Medicare should notify Medicare of their employment status at the Company, as follows:

- **Active Employees:** If you are actively working or if you are on Workers' Compensation or a Leave of Absence, you are in "current employment status". Please notify Medicare that you are in "current employment status" and that you are in a medical plan for active employees.
- **Employees on LTD:** If you are on LTD, you do <u>not</u> have coverage by virtue of "current employment status". Please promptly notify Medicare that you do <u>not</u> have coverage via "current employment status" and that you are in a medical plan for employees who are <u>not</u> in current employment status due to being on LTD.

Medicare Reduction Applies Even If You Have Not Enrolled

In circumstances where Medicare is the primary payer, the Company-sponsored plan will reduce its payment by the amount Medicare pays or should have paid, even if you do not enroll in Parts A and B. Therefore, if you do not enroll in Medicare Part B when eligible, you will be responsible for the portion of medical claims that Medicare Part B would have paid, which may be substantial. In addition, if you do not promptly notify PG&E of Medicare eligibility for yourself or an enrolled family member, please be aware that primary medical claims payments for the Medicare-eligible family member(s) may be reprocessed on a retroactive basis to pay on a secondary basis only (i.e., primary claims payments will be rescinded).

To help offset the cost of Part B premiums, the Company will provide LTD employees with a Medicare Refund Credit equal to the full cost of the standard Part B premiums for Medicare Part B coverage. In addition, the Company will provide LTD employees with a Medicare Refund Credit equal to the full cost of the standard Part B premiums for any eligible disabled Medicare-covered dependents, until the dependent(s) reach age 65. (When your dependent turns age 65, the Medicare Refund Credit will become $15 per month.) However, you must be enrolled in a PG&E medical plan, provide a copy of your Medicare card to the PG&E Benefits Service Center, and request reimbursement of your Medicare Part B premiums. PG&E will not issue reimbursement of Part B premiums on a retroactive basis, so it is important that you promptly send a copy of your Medicare card when you or your dependent(s) first obtain Part B coverage. The maximum number of reimbursements a family may receive for disabled members is three.

For Pacific Gas and Electric Company employees, the Company has retained the services of Allsup, Inc. to assist Long-Term Disability (LTD) recipients and early retirees in applying for Social Security disability benefits and enrolling in Medicare. These services are provided at no cost. If you are disabled and an LTD recipient or an early retiree, you can call Allsup, Inc. at **1-888-339-0743** to request assistance.

Medicare Part D — Prescription Drug Benefits

Employees and/or their dependents who are eligible for Medicare may not elect to enroll in Medicare's prescription drug benefits outside the Company — known as Medicare Part D Plans — and continue coverage under a Company-sponsored medical plan. The Company-sponsored medical plans all provide a prescription drug benefit equal to or better than Medicare's basic Part D benefit. Enrolling in a Medicare Part D Plan outside of the Company will result in your losing all medical and prescription drug coverage under the Company-sponsored plans. Every year, the Company provides a Creditable Coverage notice to all medical plan participants. The notice attests that the Company-sponsored medical plans' prescription drug benefits are actuarially equal to or better than the Medicare Part D basic benefit. You should keep the notice because it provides protection against Medicare Part D late enrollment penalties should you at some time in the future drop Company-sponsored medical plan coverage and enroll in a Medicare Part D Plan. For a copy of the notice or additional information, you can contact the PG&E Benefits Service Center at **1-866-271-8144**, or access a copy of the notice on mypgebenefits.com > Resources > Legal Notices.

Medicare and Active Employment

The Company is required by law to offer employees or their spouses who are age 65 or older the same array of group health plans that are available to younger employees, provided the employee is in "current employment status" (i.e., not on Long-Term Disability). Employees and their spouses/registered domestic partners have the option of choosing one of the Company-sponsored group health plans or Medicare as their primary plan.

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

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

For active employees and their spouses/registered domestic partners who turn age 65 and become eligible for Medicare, unless you instruct otherwise, the Company will assume that you are still in "current employment status" (i.e., not on LTD) and that you plan to continue working and retain the same Company-sponsored plan in which you are currently enrolled as the primary plan for you and/or your Medicare-eligible dependent(s).

Reductions/Exclusions for Duplicate Coverage

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

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

Subrogation and Reimbursement

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

- Any person or entity alleged to have caused you or your Eligible Dependent to suffer sickness, injuries or damages, or who caused or is responsible for the sickness, injuries or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injuries or damages incurred by your or your Eligible Dependent.
- Your employer.
- Any person or entity who is or may be obligated to provide health care benefits or payments to you or your Eligible Dependent, including health care benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, medical malpractice coverage, or coverage by other insurance carriers or third-party administrators.
- Any person or entity that is liable for payment to you or your Eligible Dependent on any equitable or legal theory,
- Any person or entity against whom you or your Eligible Dependent may have any claim for professional and/or legal malpractice arising out of or connected to a sickness or injury you allege or could have alleged were the responsibility of any third party.

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

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

you or your Eligible Dependent for 100% of the benefits the Plan provides or will provide to you or your Eligible Dependent.

You and your eligible dependents agree as follows - each reference to "you" and "your" below includes your Eligible Dependent and, in the case of the death of you or your Eligible Dependent, such individual's legal representative:

- That you will cooperate with the Plan and its Claims Administrators in a timely manner in protecting the Plan's legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - notifying the Plan's Claims Administrators in writing as soon as you learn that a Third Party may be liable for causing your need for health care benefits,
  - providing any relevant information requested by the Plan or its Claims Administrators,
  - signing and/or delivering such documents as the Plan or its Claims Administrators reasonably request to secure the subrogation and reimbursement claims,
  - responding to requests for information about any sickness, accident or injuries,
  - appearing at legal proceedings such as depositions and in court, and
  - obtaining the consent of the Plan or its Claims Administrators before releasing any party from liability of payment of health care expenses.
- That the Plan may terminate health care benefits for you and any of your dependents, deny future benefits, set off from any future benefits the value of benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party, and/or institute legal action against you, if you fail to cooperate in this matter or to abide by the terms of the Plan regarding the Plan's subrogation and reimbursement rights. If the Plan incurs attorney's fees and costs in order to enforce its rights of subrogation and reimbursement, including to collect third party settlement funds held by you, it has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been paid to the Plan.
- That the Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from your recovery without express written consent from the Plan or Claims Administrators; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" will not defeat this right, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment no matter how those proceeds are captioned or characterized. The proceeds available for collection will include, but are not limited to, any and all amounts earmarked as economic, non-economic, pecuniary, consortium and punitive damages, whether in the form of settlements or judgments. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine" claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- That the health care benefits paid by the Plan or its Claim Administrators may also be considered to be health care benefits advanced.
- That if you receive any payment from any Third Party or an insurer as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds received from any Third Party that are due and owed to the Plan, as stated herein, separately and alone (e.g., in a separate bank account or in your attorney's trust account), and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health care benefits or the institution of legal action against you.

- That you will transfer title to the constructive trust to the Plan for all health care benefits that have been paid or will be paid as a result of your sickness, injury or illness.
- That the Plan will be entitled to recover reasonable attorney fees from you that are incurred in collecting from you any funds held by you that you recovered from any Third Party.
- That the Plan may offset from any future health care benefits otherwise allowed the value of health care benefits paid or advanced under this section to the extent not covered by the Plan.
- That you will neither accept any settlement that does not fully compensate or reimburse the Plan without the written approval of the Plan or its Claims Administrators, nor will you do anything to prejudice the Plan's rights under the provision.
- That you will assign to the Plans all rights of recovery against Third Parties, to the extent of the reasonable value of services and health care benefits the Plan provided, plus reasonable costs of collection.
- That the Plan's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom you are seeking recovery, to be paid before any other of your claims are paid. Further, the first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment centers, that assert a right to payment from funds payable from or recovered from an allegedly responsible or responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements or judgments or other recoveries paid or payable to you or your representative on your behalf no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic and punitive damages, whether in the form of settlements or judgments. The Plan is not required to help you to pursue your claim for damages or personal injuries and no court costs or attorneys' fees may be deducted from our recovery without express written consent from the Plan or Claims Administrators; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" will not defeat this right.
- That the Plan's rights will not be reduced due to your own negligence.
- That the Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation and reimbursement provisions, including but not limited to providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party, and/or filing suit in your name, which does not obligate the Plans in any way to pay you part of any recovery the Plans might obtain.
- That the Plan shall not be obligated in any way to pursue this right independently or on your behalf.
- That if the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section also applies to the parents or guardian of the minor child.
- That in the case of a wrongful death, this section also applies to your estate, personal representative of your estate, and your heirs, legatees or beneficiaries. In the case of your death, the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate, which can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- That if the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Plan Participant, also called "member," this section will apply to any personal representative of the Plan Participant.
- If a third party causes or is alleged to have caused you to suffer a sickness, injury or damages while you are covered under the Plan, the provisions of this section will continue to apply, even after you are no longer covered.
- The Plan and the Plan Administrator (or the Claims Administrators acting on their behalf) have the authority and discretion to resolve all disputes regarding the interpretation of the language contained in these provisions, and shall have the such powers and duties as are necessary to discharge their duties and functions, including the discretionary authority to (1) construe and enforce the terms of these subrogation and

reimbursement provisions and rights, and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

For Kaiser Members Only

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

Kaiser Permanente Insurance Company
99 So. Oakland Avenue
Pasadena, CA 91101

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

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

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

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

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

When Coverage Ends

Your health care coverage under the health plans for active union-represented employees will continue until the end of the month in which:

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

Also see "Extended Benefits When Coverage Ends."

Continuing Coverage with COBRA

When coverage ends, you and your covered dependents may be eligible to continue your existing benefits under the COBRA Continuation Program. Please see "Continuing Coverage Under COBRA" for more information on continuing coverage that has ended.

Your Dependents

Your dependents' coverage will end when your coverage ends, or on the last day of the month in which they no longer qualify as eligible dependents. If you become legally separated or divorced, or if your registered domestic partnership ends, the coverage of your former spouse/registered domestic partner and his or her children (including step-children, unless you have adopted them) will end on the last day of the month in which the legal separation, divorce or termination of registered domestic partnership becomes final. You may, however, continue

to cover your registered domestic partner's children if those children were born or adopted during the period of your registered partnership. You must notify the PG&E Benefits Service Center within 31 days of the effective date of divorce, legal separation, termination of a registered domestic partnership or a dependent's loss of eligibility. Also see "Extended Benefits When Coverage Ends."

Extended Benefits When Coverage Ends

Hospitalization

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

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

Disability

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

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

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

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

Extended Dental Benefits

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

Continuing Coverage Under COBRA

COBRA Coverage

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

Don't Miss the Deadlines!

There are very specific timelines and enrollment requirements that must be followed in order to obtain COBRA continuation coverage. It is important that you and your covered eligible dependents read all the information that is provided regarding COBRA continuation coverage. If you or your dependents have questions about COBRA coverage, you are encouraged to call the PG&E Benefits Service Center at **1-866-271-8144 and select the COBRA option.** If your Company-sponsored health care coverage ends, you and your covered dependents may be eligible for continued benefit coverage through COBRA.

Eligibility for COBRA

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

Definition of a Qualified Beneficiary

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

- an employee or retiree;
- the spouse of a covered employee or retiree; or
- an eligible dependent child of a covered employee or retiree.

If you have a child born to or adopted by you while you are covered through COBRA, your newborn or adopted child will also be considered a qualified beneficiary, as long as you add the child to your COBRA coverage during a special or open enrollment period that occurs during the COBRA coverage period.

Registered Domestic Partners

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

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

COBRA Qualifying Events

18-Month Events

You and your covered dependents who are qualified beneficiaries have the option to continue coverage for up to 18 months, calculated from the date of the qualifying event, if one of the following qualifying events causes a loss of coverage under the Plan:

- your employment with the Company terminates for any reason (including voluntary resignation or retirement) other than for gross misconduct; or

- your Company-sponsored group health coverage would otherwise end due to a reduction in your work hours.

36-Month Events

Your covered dependents who are qualified beneficiaries have the option to continue coverage for up to a total of 36 months, calculated from the date of the qualifying event, if one of the following qualifying events causes a loss of coverage under the Plan:

- your death occurs while being covered as a plan participant (your eligible covered dependents have a choice of continuing their coverage under COBRA or under the Survivor Medical Benefits offered by the Company for surviving dependents of Company employees);
- you and your spouse become divorced or legally separated;
- your dependent child no longer qualifies as an eligible dependent under the Company-sponsored plans or
- your entitlement to Medicare*.

*If, within 18 months after becoming entitled to Medicare, you subsequently lose coverage under the Plan due to your termination of employment or reduction in hours, your spouse and dependent child become entitled to COBRA coverage for a maximum period that ends 36 months after you become entitled to Medicare. You remain entitled to a basic maximum period that ends 18 months after the termination of employment or reduction of hours.

Spouse and Dependent Elections

Please note that if one of the 36-month qualifying events occurs while you and your eligible dependents are covered on an 18-month COBRA continuation period, your spouse and/or eligible dependent children who are qualified beneficiaries may elect to continue coverage under COBRA for up to 36 months from the date of the first qualifying event.

Even if you do not elect COBRA continuation coverage, your spouse and covered dependents who elected COBRA may still be eligible for a second qualifying event.

Extension of COBRA Coverage Due to Disability

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

- the qualifying event was your termination of employment or reduction of hours; and

you or your qualified beneficiary is disabled as determined by Social Security within the first 60 days of COBRA coverage.

To qualify for this extension, you must notify the third-party **COBRA administrator** at **1-866-271-8144** within 60 days of the later of:

- the date of the Social Security Administration determination that you, your spouse, or your dependent child is disabled;
- the qualifying event date;
- the loss of coverage date; or
- the date you (or your spouse/dependent) were notified of your obligation to provide the notification of disability determination and the Plan's procedures for providing the notification (this section of the SPD is intended to be the notification of this obligation).

Notwithstanding the foregoing, you must request a disability extension before the end of your initial 18-month COBRA coverage period. You must also notify the COBRA administrator within 30 days of the date on which Social Security determines that you or your qualified beneficiary is no longer disabled.

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

- either 29 months after the date of the qualifying event, or the first day of the month that is more than 30 days after Social Security determines that you or your dependent are no longer disabled, whichever is earlier; or
- the date specified under "When COBRA Coverage Ends" below.

Health Care Flexible Spending Account ("Health FSA") COBRA Coverage

If your Health FSA coverage ends because of a COBRA-qualifying event, COBRA continuation coverage for your Health FSA will be available only if the maximum benefit available under the Health FSA for the year as of the date of the qualifying event equals or exceeds the COBRA premium that applies for coverage for the remainder of the plan year. COBRA coverage ends at the end of the plan year in which the qualifying event occurs. Notwithstanding the foregoing, you can carryover an unused balance up to a certain amount for the duration of your 18- or 36-month continuation period.

When COBRA Coverage Ends

In general, your COBRA coverage will remain in place for the 18-month, 29-month, or 36-month periods described above. However, COBRA coverage will end before the maximum time periods if:

- you fail to pay the required premium when due (failure to meet COBRA's payment deadline — even by a day — will end your COBRA coverage and you will not be able to re-enroll);
- you or your dependents become entitled to Medicare after electing COBRA (Medicare entitlement terminates coverage only for the individual covered by Medicare);
- you or your dependents obtain other group health coverage (with the exception of PG&E's Retiree Medical plan);
- your or your dependent's coverage is terminated for cause, such as submitting false claims;
- the Company-sponsored group health care plans are terminated.

You must notify the COBRA administrator at 1-866-271-8144 if you become covered by another group health plan.

Cost of COBRA Continuation Coverage

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

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

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

Additional Information

For quick access to general and specific information regarding your plan's COBRA coverage, please visit **https://cobra.optumfinancial.com**. You may also call the **COBRA administrator at 1-866-271-8144**.

How to Obtain COBRA Continuation Coverage

If you get divorced or legally separated, dissolve a registered domestic partnership, or if your dependent child no longer qualifies as an eligible dependent under the plans, you must call the PG&E Benefits Service Center within 31 days of the eligible change-in-status event, or initiate a Life Event transaction on PG&E's Benefits Portal, to drop the former dependent(s). To request COBRA enrollment materials, either you or the dependent(s) losing coverage must notify the PG&E Benefits Service Center within 60 days of the occurrence of the COBRA-qualifying event or the last day of eligible coverage — whichever occurs last.

If you lose coverage due to your termination of employment/reduction of hours, death, or entitlement to Medicare, the PG&E Benefits Service Center will automatically provide you or your dependents with COBRA enrollment materials.

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

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

If you need to report the occurrence of a qualifying event or if you have any questions about whether or not a dependent is eligible for COBRA continuation coverage, contact the PG&E Benefits Service Center at **1-866-271-8144**. Be sure to let the PG&E Benefits Service Center know the address to which any COBRA packages should be sent.

To obtain complete details of the terms and conditions of continued coverage through COBRA or to request the required COBRA forms to elect COBRA coverage, contact the **COBRA administrator at 1-866-271-8144**.

Medical Coverage for Active Employees

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

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation.

This section describes the PG&E-sponsored medical plans that are offered to eligible active employees and their eligible dependents, including prescription drug coverage and mental health and substance use disorder coverage. Employees on Long-Term Disability (LTD) are eligible for different medical, prescription drug, and mental health/substance use disorder coverage; see *Medical Coverage for Participants on Long-Term Disability.*

Eligible active employees are eligible to enroll in one of the following two medical plan options:

- **the Health Account Plan (HAP) administered by Anthem Blue Cross (the Anthem HAP); or**
- **the Health Account Plan (HAP) administered by Kaiser Permanente Insurance Company (the Kaiser HAP).**

All active employees are eligible for the Anthem HAP. The Kaiser HAP may also be available to you if you live in the Kaiser Permanente service area. As an alternative, you may elect to decline (opt out of) medical coverage.

The Health Account Plan (HAP)

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

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The HAP at a Glance

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

The information in these charts is intended to be a summary of the benefits provided by the HAP as of January 1, 2026. The information contained in the applicable service provider agreements between The Pacific Gas and Electric Company, Anthem Blue Cross, (referred to as "Anthem" in this document) and Kaiser Permanente Insurance Company (referred to as Kaiser Permanente," or "Kaiser" in this document) shall govern in case of conflict between this chart and the service provider agreements. Please refer to the most recent information about your medical plan benefit options, which are updated annually in the Open Enrollment materials.

Provision	
General	Annual deductible: ▪ $1,000/person; $2,000/family Annual out-of-pocket maximum (includes deductible): ▪ $2,400/person; $4,800/family Coinsurance: ▪ You pay 10% for primary care (beyond four free visits) with no deductible. ▪ You pay either 10% or 20% coinsurance depending on the type of provider and service. ▪ You pay no coinsurance for preventive care. For Kaiser members, preventive care includes all services defined within the Kaiser National Preventive List on kp.org. No lifetime benefits maximum except for infertility services. No pre-existing condition exclusions.
	▪ All plan benefits and out-of-pocket maximums are based on eligible expenses only. For the definition of "eligible expenses," see *Glossary*. ▪ Both network and non-network covered expenses apply to deductible and out-of-pocket limits. ▪ Family deductible and out-of-pocket limits can be met by any combination of family members. Any family member can reach the single annual deductible and the plan will start to pay benefits for that person, even if the family annual deductible has not yet been met.
Hospital Stay	▪ You pay 20%, subject to deductible; expenses apply to out-of-pocket maximum. ▪ For the Anthem HAP: ▫ pre-authorization is required; $300 penalty if not obtained. ▫ Out-of-network hospital-based physicians' services at in-network facility allowed at billed charges. ▪ For the Kaiser HAP, your network physician will request pre-authorization.
Skilled Nursing Facility	▪ You pay 20%, subject to deductible; expenses apply to out-of-pocket maximum. ▪ No day maximum. ▪ For the Anthem HAP, pre-authorization is required; $300 penalty if not obtained

Emergency Room	▪ You pay 20% for emergency room and physician, subject to deductible; expenses apply to out-of-pocket maximum. ▪ Accidental injury and medical emergency pay as emergency. ▪ Services billed by a provider other than the hospital will be paid according to the appropriate benefit category level. ▪ For the Anthem HAP, out-of-network hospital-based physicians' services at in-network facility allowed at billed charges. ▪ For the Kaiser HAP: out-of-network urgent and emergent care allowed at billed charges. There is a charge for same day and same condition visits.
Outpatient Hospital Care	▪ You pay 20% for outpatient hospital care (including surgery, chemotherapy, radiation and dialysis services), subject to deductible; expenses apply to out-of-pocket maximum. ▪ Pre-authorization required for outpatient surgery.
Maternity Care (professional)	▪ Routine pre-natal and post-natal visits are free. ▪ You pay 20% after deductible for screenings and tests (for example, sonograms). ▪ You pay 20% after deductible for delivery. ▪ Includes nurse midwives but excludes lay midwives and doulas (for the Kaiser HAP, services must be received from network providers).
Well-Baby Care	▪ Fully covered (no deductible) up to age two.
Women's Preventive Care	▪ For Anthem HAP members: Birth control and contraceptive devices on the HAP Free Drug List are fully covered (no deductible) if obtained through mail-order (if purchased at a retail pharmacy, retail coinsurance applies). Preventive drugs on the ACA preventive services list are provided at $0 cost share. ▪ For Kaiser HAP members: With a prescription, birth control and contraceptive devices fully covered (no deductible) at retail and mail order. Without a prescription, retail cost will be charged for retail purchases. ▪ Contraceptive counseling, and implantable and injectable contraceptives fully covered (no deductible). ▪ Voluntary sterilization fully covered (no deductible).

Telemedicine	**Anthem Members:** Primary care telemedicine visits with Anthem network providers will count toward your four free visits under the Health Account Plan (HAP). Coinsurance for primary care or specialty telemedicine visits is the same as for in-person visits. **Anthem LiveHealth Online** Easily accessible and convenient, LiveHealth Online saves you time and the hassle of driving to a health care provider's office, helping you get the right care at the right time. Anthem members can use a computer or mobile device to virtually meet with a board-certified doctor, psychiatrist, or a licensed therapist from anywhere—including home and work. Learn more at livehealthonline.com. You don't have to be enrolled in the Anthem HAP to use *LiveHealth Online*, but if you are an Anthem HAP member, the cost of your *LiveHealth Online* visit will be covered by the HAP. You'll be responsible only for your co-insurance and you can use your Health Account or Health Care Flexible Spending Account (HCFSA) to pay for this. To access *LiveHealth Online* via your personal computer, register at LiveHealthOnline.com, or download the app to get started on a mobile device. When virtually meeting with a provider at work, you must use your own cell service to connect. Virtual doctor consultations cannot be accessed through PG&E's Wi-Fi. For additional information about Anthem's telemedicine program, please email **customersupport@livehealthonline.com,** or call **1-855-603-7985.** **Kaiser Members:** All Kaiser HAP telemedicine visits continue to be free and therefore, do not count toward your four free primary care visits. ***Kaiser Video Visits*** ▪ With Kaiser Permanente's telemedicine feature, Video Visits, along with ongoing features like telephone and call-back appointments, you have more flexibility to meet virtually with a doctor anytime, anywhere—including home and work—for consultation when you're sick, have a rash or even to receive a prescription. ▪ Visit kp.org/mydoctor/videovisits for additional information about Video Visits.

Office Visits	▪ First four visits to a primary care physician each year, for employee and each enrolled dependent (includes general or family practice, internal medicine, pediatrics, family nurse practitioner, obstetrics and gynecology) fully covered (no deductible); if one of first four visits is a physical exam, this counts toward the four free visits; you pay 10% for all subsequent visits, not subject to deductible; expenses apply to out-of-pocket maximum. ▪ Includes medically necessary non-routine vision and hearing care. ▪ For the Anthem HAP, the primary care physician (PCP) must be trained as a generalist for member to qualify for free visits. ▪ You pay 20% for all specialist office visits, subject to deductible; expenses apply to out-of-pocket maximum.
PG&E Health Centers	▪ All active Health Account Plan (HAP)-eligible PG&E employees may visit the PG&E Health Centers. ▪ For active employees with Anthem HAP coverage, the clinic will bill Anthem for services just like other clinics and providers do. ▪ For active employees with Kaiser HAP or other non-PG&E coverage, full payment for all services with cost will be collected at the time of service. ▪ Visit mypgebenefits.com > Physical Health > Health Centers to view the locations. Key services include: ▪ Coordinated and customized primary and preventive care services ▪ Same day acute and urgent care services ▪ Biometric (Health) screenings ▪ Clinical lab services ▪ Health education and coaching ▪ Condition care management ▪ Physical therapy ▪ Chiropractic and acupuncture treatments ▪ Occupational health (work-related injury/discomfort; Workers' Compensation) ▪ Flu shots, immunizations and travel health ▪ Secure electronic medical records ▪ Virtual video visits ▪ InBody body composition testing
Urgent Care Visits	▪ Included as part of the four free visits to a PCP (employee and each enrolled dependent); you pay 10% for all subsequent visits, not subject to deductible; expenses apply to out-of-pocket maximum.
Routine Physical Examinations	▪ Free. ▪ Includes routine preventative gynecological exam.
Immunizations and Injections	▪ You pay 20% for injections, subject to deductible; expenses apply to out-of-pocket-maximum. ▪ Age-/gender-specific routine preventive adult and child immunizations and approved travel immunizations are fully covered (no deductible).

Routine Eye Examinations	▪ For Anthem HAP members: not covered (for details on routine vision coverage offered to employees, see *Vision Coverage*). ▪ For Kaiser HAP members: you pay 20%, subject to the deductible; expenses apply to out-of-pocket maximum.
X-rays and Lab Tests	▪ Most preventive X-ray and lab tests are free if included on list of free preventive services, available at mypgebenefits.com (no deductible). ▪ You pay 20% for all other procedures, including diagnostic tests, subject to deductible; expenses apply to out-of-pocket maximum. **Anthem Members:** If your doctor orders lab tests or X-rays as part of your office visit, the exam may be free if it's one of your four free visits—but you could be charged for the lab tests and X-rays. Anthem also requires preauthorization for certain X-rays, advanced imaging and musculoskeletal procedures in order for those procedures to be covered. This applies to network and non-network providers. Call Anthem Member Services at the phone number on your ID card to find out if a procedure requires preauthorization. Be sure to find out if your lab is a network lab. You'll pay more for out-of-network labs.
Home Health Care and Home Hospice Care	▪ You pay 20% for home health care, subject to deductible; expenses apply to out-of-pocket maximum. ▪ For the Anthem HAP: precertification required. ▪ For the Kaiser HAP: your network physician will request pre-authorization. ▪ Includes home infusion therapy and nursing care. ▪ Hospice care fully covered (no deductible). ▪ Home health care not covered while covered person receives hospice care. ▪ Excludes custodial care.
Outpatient Physical/Occupational/Speech Therapy (including Speech Therapy for learning disabilities)	▪ Once you have met your HAP deductible for the year, you pay 10% for the first five visits and 20% for all subsequent visits, expenses apply to out-of-pocket maximum. For purposes of determining coinsurance rates, tallying of the first five visits does not begin until the deductible has been met. ▪ Not combined with any other therapy. ▪ All visits may be reviewed for medical necessity; for the Anthem HAP, precertification is required for all visits beyond the 24th visit in a calendar year.

Outpatient Prescription Drugs	▪ You pay 15% for up to 30-day supply of formulary generic for Anthem Blue Cross members, up to 100-day supply for Kaiser HAP members, subject to deductible, at retail/pharmacy; for Anthem Blue Cross members, maximum of two refills at retail for most maintenance drugs, and then mail order must be used. No mandatory mail order for Kaiser HAP members. ▪ You pay 25% for up to 30-day supply of formulary brand for Anthem Blue Cross members, up to 100-day supply for Kaiser HAP members, subject to deductible, at retail/pharmacy; for Anthem Blue Cross members, maximum of two refills at retail for most maintenance drugs, and then mail order must be used. No mandatory mail order for Kaiser members. ▪ You pay 10%, subject to deductible, for up to 90-day supply of generic at mail order for Anthem Blue Cross members; up to 100-day supply for Kaiser HAP members. ▪ You pay 20%, subject to deductible, for up to 90-day supply of brand at mail order for Anthem Blue Cross members; up to 100-day supply for Kaiser HAP members. ▪ Expenses apply to out-of-pocket maximum. ▪ Certain preventive drugs fully covered (no deductible) at mail order only for Anthem Blue Cross members. Preventive drugs on the ACA preventive services list are provided at $0 cost share. ▪ Certain preventive drugs fully covered (no deductible) at either a Kaiser Permanente pharmacy or mail order for Kaiser HAP members. Certain over-the-counter drugs fully covered (no deductible) at either a Kaiser Permanente pharmacy or mail order for Kaiser HAP members with a prescription. Without a prescription, Participant pays retail cost (such expense does not count toward the out-of-pocket maximum). ▪ Anthem HAP members: Generic Incentive Provision and Step Therapy Provision apply. See *Prescription Drug Coverage* for more information. ▪ View a list of free drugs by visiting mypgebenefits.com > Physical Health > Medical Anthem Member or Medical Kaiser Member.
Inpatient and Outpatient Mental Health Care	▪ You pay 20% for inpatient care, subject to deductible; expenses apply to out-of-pocket maximum. Pre-authorization required; $300 penalty for Anthem HAP members who fail to obtain pre-authorization. ▪ You pay 10% for outpatient care, not subject to deductible; expenses apply to out-of-pocket maximum. See *Mental Health and Substance Use Disorder Coverage* for more information.
Inpatient and Outpatient Substance Use Disorder	▪ You pay 20% for inpatient care, subject to deductible; expenses apply to out-of-pocket maximum. Pre-authorization required; $300 penalty for Anthem HAP members who fail to obtain pre-authorization. ▪ You pay 10% for outpatient care, not subject to deductible; expenses apply to out-of-pocket maximum.
Mandated Treatment for DOT-NRC, and OSHA-certified crane operators, or PG&E Self-Identification Program for Alcohol/Substance Use Disorder Treatment	▪ Fully covered (no deductible). ▪ Requires authorization by Carelon Behavioral Health or an onsite EAP counselor.

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

How the HAP Works

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

Important Information

For additional important information about the Anthem HAP and Kaiser HAP, see *Glossary* and "Claims and Appeals Process."

Network Providers

The HAP administered by Anthem Blue Cross (the "Anthem HAP") provides coverage through an Anthem Blue Cross preferred provider organization (PPO), a network of doctors, hospitals, laboratories and other providers who have agreed to provide services at negotiated rates. Anthem HAP members may go directly to any provider or specialist of your choice without pre-authorization from a primary care physician (PCP). If you receive care from a NETWORK PROVIDER who charges more than the negotiated rate, you will be held harmless for those charges above the negotiated rate. Similarly, if a network provider has referred you to a NON-NETWORK PROVIDER, you will not be responsible for fees over the maximum allowed amount.

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

Inside California

The Anthem HAP uses the Anthem Blue Cross Prudent Buyer Plan PPO network. You can locate network providers by calling Anthem Blue Cross directly or by visiting its website. The Kaiser HAP uses the Kaiser Permanente EPO network.

Outside of California, But Within the United States

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

- call Anthem Blue Cross Member Services at **1-800-964-0530**; or
- visit the Anthem Blue Cross website at anthem.com/ca/pge.

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

Outside of the United States

Outside of the United States, only emergency/URGENT CARE is covered. See "Treatment Away from Home."

Non-Network Providers

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

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

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

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

Continuity of Care

You may have to find a new provider or health care facility when:

- the HAP's network changes and the provider or facility you have is not in the new network; or
- you are already enrolled in the HAP and your provider or facility stops participating in the HAP's network.

In some cases, you may be able to keep going to your current provider or facility to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. A continuing care patient is an individual who is undergoing treatment for one of the following:

- a serious and complex condition;
- institutional or inpatient care;
- pregnancy;
- terminal illness; or
- a scheduled non-elective surgery.

Routine procedures, minor illnesses, and elective surgical procedures generally are not covered under this continuity of care provision.

If you qualify as a continuing care patient, you will be notified by Anthem or Kaiser (as appropriate), and you will be given the opportunity to submit a request for continuity of care. If your request is approved, you will generally be entitled to continue your care, subject to the same terms and conditions that applied when your provider or facility was in the network, until the earlier of: (1) the end of a 90-day period that begins on the date you receive notice that you qualify as a continuing care patient, or (2) the date on which you are no longer a continuing care patient with respect to that provider or facility.

Health Account

The Health Account Plan (HAP) comes with the PG&E-funded Health Account to help you cover your health expenses. You can use your Health Account to pay for eligible out-of-pocket medical, prescription drug, mental health and substance use disorder, dental and vision expenses as long as they are certified by the IRS as "eligible expenses". Please see *Health Account* for more information.

Deductibles

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

Each year, you're responsible for paying 100% of covered charges until you meet the annual deductible:

Level of Coverage	Annual Deductible
One Person	$1,000
Family	$2,000 (maximum $1,000 per person)

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

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

Plan Maximums

Out-of-Pocket Maximums

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

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

For the Anthem HAP, charges for non-covered services, penalties for not obtaining pre-authorization, and amounts over the maximum allowed amount, and any other ineligible expenses do not apply toward the annual out-of-pocket maximum.

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

Lifetime Maximums

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

Infertility Treatments	▪ Deductible required ▪ You're responsible for 20% of covered charges ▪ $7,000 lifetime benefit maximum; includes balances from prior through the HAP – (Combined between both HAP vendors in Anthem or Kaiser plans); (Prescription drugs for infertility treatments do not count towards $7,000 maximum)

Coinsurance and Benefit Percentages

Coinsurance is the percentage of the covered cost you owe after paying the ANNUAL DEDUCTIBLE. For some services, such as additional primary care past your four free visits each year, you don't have to meet the annual deductible

before coinsurance applies, but for most services the deductible applies. Coinsurance amounts are listed under the Summary of HAP Benefits.

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

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

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

Outpatient Hospital Services

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

Physician Office Visits

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

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

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

How Benefits Are Determined

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

Maximum Allowed Amount– Anthem HAP

If you are in the Anthem HAP, Anthem Blue Cross will determine the maximum allowed amount for covered services rendered by or on behalf of a non-network PHYSICIAN. For claims subject to the No Surprises Act, the maximum allowed amount will be determined by Anthem in accordance with federal law.

Covered Health Services

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

A covered health service is a MEDICALLY NECESSARY health care service or supply described under *What the HAP Covers* as a covered health service and which is not excluded under *What the HAP Does Not Cover*, such as experimental or investigational services or unproven services.

Covered health services must be provided:

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

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

Medically Necessary Services

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

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

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

Special Situations — Emergency Care and Treatment Away from Home

Emergency Care

If you or a covered family member experiences a medical emergency, seeking prompt care should be the first priority. Under the HAP, emergency care is provided 24 hours a day, 7 days a week, anywhere in the world.

A medical emergency is defined as a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that failure to get immediate medical care could be life-threatening or cause serious harm to bodily function.

Examples of medical emergencies include:

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

It is important to understand that some conditions, such as colds, or symptoms, such as earaches, sprains and rashes, although potentially serious, may not require a visit to the emergency room. In these cases, you should always call your regular PHYSICIAN first.

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

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

Receiving Care in Other Kaiser Permanente Regions

If you are enrolled in the Kaiser HAP, you will probably receive most services in the SERVICE AREA of the Kaiser Permanente REGION where you live or work. If you are in the service area of another Kaiser Permanente region, you may receive services from NETWORK PROVIDERS in that region, though services that require a referral or PRE-AUTHORIZATION may differ among regions. For information about network providers or covered services in another region, please call Kaiser Permanente Customer Service (**1-800-663-1771 for the Northern California Region or 1-800-533-1833 for the Southern California Region**).

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

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

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

You do not need to get PRE-AUTHORIZATION from Kaiser Permanente to get emergency services (from the nearest hospital emergency department or independent freestanding emergency department) or urgent care from non-network providers outside the Kaiser Permanente service area. Post-stabilization services that are part of the same visit for Emergency Services are covered until your attending emergency physician determines you are able to travel (using non-medical/non-emergency medical transportation) to a Network facility within a reasonable distance considering your medical condition. However, you (or someone on your behalf) must get pre-authorization from Kaiser Permanente for you to get covered post-stabilization services from non-network providers.

Emergency Services

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

Emergency services are available from hospital emergency departments 24 hours a day, 7 days a week.

An emergency medical condition is defined as a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that failure to get immediate medical care could be life-threatening or cause serious harm to bodily function. See Emergency Care above for examples of emergency medical conditions.

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

Post-Stabilization Services

Post-stabilization services is defined as medically necessary and related to your emergency medical condition when they are part of the same visit for screening and stabilization of your emergency medical condition. Post-stabilization services received from a non-network provider, including inpatient care at a non-network hospital, is covered only if Kaiser Permanente provides pre-authorization for the care.

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

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

Out-of-Area Urgent Care

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

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

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

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

Payment and Reimbursement

If you receive emergency services outside the Kaiser Permanente service area from a non-network provider, you should ask the provider to submit a bill to Kaiser Permanente. For urgent care, you may have to pay the provider and file a claim for reimbursement unless the provider agrees to bill Kaiser Permanente. To request payment of the bill or reimbursement in the event that you pay the provider directly, you must file a claim as described in the "Claims and Appeals Process."

Cost Sharing

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

Treatment Away from Home

While Working Away from Home

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

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

Non-Emergency Care While Traveling Away from Home

For Anthem HAP members, if you are traveling in the United States, you may seek care from any licensed provider. If you are traveling out of the country, you may seek urgent or emergency care from any licensed provider. However, before leaving the U.S., you can call 1-800-810- 2583 and a BlueCard coordinator can provide you with a list of Blue Cross Association participating hospitals in several international cities. You may also find this information on Anthem's website at anthem.com. For inpatient care at a network BlueCard HOSPITAL, you pay only the applicable deductibles and coinsurance. The provider files the claim for you.

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

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

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

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

Dependent Children Living Away from Home

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

If you are in the Anthem HAP: If your enrolled dependents are outside of California, they may access benefits with the BlueCard program, which enables members traveling or living outside their home state to access a broader network of doctors and hospitals at discounted rates through other Blue Cross/Blue Shield plans. To locate BlueCard providers, call 1-800-810- 2583. This number is also printed on the back of your ID card for handy reference.

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

Medical Management Programs

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

Not Applicable for Secondary Coverage

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

Medical Management – Anthem Blue Cross

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

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

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

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

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

Utilization Review Program

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

Participating providers will initiate the review on your behalf. A non-participating provider may or may not initiate the review for you. In both cases, it is your responsibility to initiate the process and ask your physician to request pre-service review. If you receive any service or care that is subject to utilization review and do not follow the procedures set forth in this section, your benefits may be reduced, and a $300 penalty may apply.

Utilization Review Requirements

Utilization reviews are required by the Anthem HAP for:

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

Review Stages

There are three stages of utilization review:

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

Effect on Benefits

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

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

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

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

How to Obtain Utilization Reviews

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

Pre-Service Reviews

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

- For all scheduled services that are subject to utilization review, you or your physician must initiate the pre-service review at least five working days prior to when you are scheduled to receive services.
- Physicians who are network providers will initiate the review on your behalf. A non-network provider may initiate the review for you, or you may call Anthem Blue Cross directly. The number for pre-authorization and pre-service review is 1-800-274-7767. This number is printed on your ID card.
- If you obtain certification for a service but the certified service is not rendered within 60 days of obtaining the certification, or if the nature of the service changes, a new pre-service review must be obtained.
- Anthem Blue Cross will certify services that are medically necessary and appropriate. For inpatient hospital stays, Anthem Blue Cross will, if appropriate, certify a specific length of stay for approved services. You, your physician and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

- If pre-service review was not performed, you, your physician or the provider of the service must contact Anthem Blue Cross for concurrent review. For an emergency admission or procedure, Anthem Blue Cross must be notified within one working day of the admission or procedure, unless extraordinary circumstances prevent such notification within that time period.
  - In determining "extraordinary circumstances," Anthem Blue Cross may take into account whether or not your condition was severe enough to prevent you from notifying them, or whether or not a member of your family was available to notify Anthem Blue Cross for you. You may have to prove that such "extraordinary circumstances" were present at the time of the emergency.
- When NETWORK PROVIDERs have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a NON-NETWORK PROVIDER to call the number printed on your identification card or you may call directly. The number for pre-authorization and pre-service review is 1-800-274-7767. This number is printed on your ID card.

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

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

Retrospective Reviews

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

Authorization Program

The Anthem HAP Authorization Program provides PRE-AUTHORIZATION for certain "special services." When your PHYSICIAN is a NETWORK PROVIDER, it is your physician's responsibility to obtain pre-authorization before you receive any service subject to the Authorization Program. When your physician is a non-network provider, it is your responsibility to obtain pre-authorization before you receive any service subject to the pre-authorization process. Call Anthem Blue Cross' pre-authorization and pre-service review at **1-800-274-7767**, which is printed on your ID card.

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

Services Requiring Authorization

Special Services

Pre-authorization is required to obtain benefits for:

- Organ and tissue transplants; see "Organ and Tissue Transplants."
- Transplant expense benefits; see "Transportation and Lodging."
- Home health care; HOSPICE, or home hospice care; see "Home Health Care and Hospice Care."

- Admissions to a SKILLED NURSING FACILITY; see "Skilled Nursing Facility."
- Purchase or rental of durable medical equipment for which the total price is equal to or greater than $1,000 (a $300 penalty is assessed if pre-authorization is not obtained).

Effect on Benefits

Special Services

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

When Authorization Will Be Provided

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

Special Services

Organ and Tissue Transplants

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

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

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

Transplant Travel Expense Benefits

- Authorizations for transplant travel expense benefits will be provided for the recipient and one companion (up to two companions if the transplant recipient is a child) only if all of the following criteria are met:
  - The procedure is for transplantation of liver, heart, heart-lung, lung, kidney-pancreas, kidney, cornea, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures, and authorized by Anthem Blue Cross;
  - The organ transplant must be performed at a specific Center of Medical Excellence (CME) or at a pre-authorized participating kidney or cornea transplant facility; and
  - The specific CME or other qualifying facility is 75 miles or more from the recipient's home, except in the case of bariatric surgery or gender-affirming surgery, which is 50 miles.

Home Health Care

See "Home Health Care and Hospice Care."

- Authorizations for home health care services will be provided only if all of the following criteria are met:
  - The services are medically necessary and appropriate and can be safely provided in the beneficiary's home, as certified by the attending physician;

- The attending physician manages and directs the beneficiary's medical care at home; and
- The attending physician must establish a definitive treatment plan which must be consistent with the beneficiary's medical needs and must list the services to be provided by the home health agency.

Skilled Nursing Facility

See "Skilled Nursing Facility."

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

Durable Medical Equipment

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

How to Obtain an Authorization

For Special Services

To obtain pre-authorization, you or your physician must call the Anthem Blue Cross pre-authorization and pre-service review at **1-800-274-7767** prior to receiving services.

Medical Necessity Review Process

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

The review process follows the same procedures and timing as the benefit claim process. See the "Claims and Appeals Process." In addition:

- All pre-authorization, pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and Anthem Blue Cross Medical Policy. These criteria and policies are developed and approved by practicing providers not employed by Anthem Blue Cross and are evaluated at least annually and updated as standards of practice or technology change. Requests satisfying these criteria are certified as MEDICALLY NECESSARY. Review Coordinators are able to approve most requests.
- If the request fails to satisfy these criteria or medical policies, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals who are clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting PHYSICIAN is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.
- Only the Peer Clinical Reviewer may determine that the proposed services are not MEDICALLY NECESSARY or not appropriate.

- Reviewers may be Anthem Blue Cross employees or an independent third party chosen at the sole and absolute discretion of Anthem Blue Cross.
- You or your PHYSICIAN may request copies of specific criteria and/or medical policies by writing to the address shown on your Anthem Blue Cross identification card. Medical necessity review procedures may be disclosed to health care providers through provider manuals and newsletters.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are MEDICALLY NECESSARY is based on the clinical information provided. Payment is based on the terms of your coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage; or
- You are not eligible for coverage when the service is actually provided.

Personal Case Management

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

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

These Are Examples

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

How Personal Case Management Works

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

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

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

Alternative Treatment Plan

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

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

The Effect Personal Case Management Has on Benefits

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

Third Parties

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

Medical Management Programs – Kaiser Permanente

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

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

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

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

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

Utilization Review Program

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

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

Review Stages

The Kaiser HAP has several stages of utilization review:

- **Precertification review** includes eligibility verification and confirmation, determination of covered services and communication with the network provider and/or you in advance of the procedure, service or supply. Utilization review includes pre-service discharge planning or need for specialized programs such as case management, if applicable.
- **Concurrent review** monitors on an ongoing basis your health care services in the inpatient setting in order to assess your clinical condition and the ongoing delivery of medical services and treatments to determine Covered Services. Concurrent review includes patient management that takes place at a network facility during inpatient care or during an ongoing outpatient course of treatment.
- **Retrospective review** reviews services that have already been provided. When performed, this applies to initial certification after the service has been provided or when you are no longer an inpatient or receiving the service in order to evaluate and audit medical documentation subsequent to services being provided.
- **Discharge planning** assists you as your medical condition changes and you transition from the inpatient setting. Discharge planning may be initiated at any stage of the Patient Management process. Assessment of potential discharge planning needs begins at the time of notification, and coordination of discharge plans commences upon identification of post-discharge needs during PRE-AUTHORIZATION or concurrent review. This program will include evaluation of alternate care settings and identification of care needed after discharge. The goal is to provide continuing quality of care and to avoid delay in discharge due to lack of outpatient support.
- **Case management** manages ongoing care if your medical condition requires the assessment, planning, facilitation and education about options to meet your needs to promote quality, cost-effective outcomes.
- **Disease management/health education** features disease management programs that focus on improving the management of care for those with certain medical diagnoses or risk factors. The disease management programs shall include identification, stratification and intervention for those who can benefit from improved care. Kaiser Permanente may also administer health education and wellness programs with a focus on outreach to encourage you to receive preventive care and participate in health education and other similar programs.
- **The Health Care Assistance line** provides you with access to registered nurses experienced in providing information on a variety of health topics. Kaiser's advice nurses can help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern, tell you what to do if a network provider is closed, or advise you about what to do next, including making a same-day appointment for you if it's medically appropriate. To contact an advice nurse, call the number for your REGION (1-866-454-8855 for the Northern California Region or 1-888-576-6225 for the Southern California Region).

Pre-Authorization and Referrals

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

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

- Your personal network physician;
- Network Generalists in internal medicine, pediatrics, and family practice;

Pre-authorization requirements are based on the region in which you are receiving services. For care received in a Kaiser Permanente facility or by Kaiser Permanente providers, authorization is managed by your physician and a component of your physician's referral within the Kaiser system. For care received outside a Kaiser Permanente facility or by non-Kaiser Permanente providers, your physician will request Pre-authorization and or referral for care.

For more information about Pre-authorization for your region visit your regional Utilization Management site.

- California (Northern): https://healthy.kaiserpermanente.org/northern-california/pages/utilization-management.
- California (Southern): https://healthy.kaiserpermanente.org/southern-california/pages/utilization-management.

The following are examples of Services that may require prior authorization:

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

Step Therapy

Step therapy is a protocol that may apply to certain services including but not limited to or prescription drugs that require you to use a lower level of treatment, or generic or other brand drug first prior to the more intensive treatment or prescribed drug. If the different service or other prescription drug is not effective, then the Plan will cover a higher level of treatment or different drug. If a lower level of treatment is not necessary, appropriate, and feasible, the decision will be based upon your individual medical need(s).

If the Plan denies a service or prescription drug because prior authorization was not obtained, or if a step-therapy exception request is denied, you may submit an appeal to obtain coverage. For information on how to submit an appeal, see "Claims and Appeals Process."

Referrals

You are required to obtain a referral from your network physician prior to receiving specialty care services under the Plan. If you receive specialty care services for which you did not obtain a referral, you will be responsible for all the charges associated with those services. A Network Physician's written or verbal recommendation that you obtain non-covered Services (whether Medically Necessary or not) is not considered a referral and is not covered.

A referral is limited to a specific Service, treatment, series of treatments and period of time. All referral Services must be requested and approved in advance. You will receive a copy of the written referral when it is approved. Your Plan will not pay for any care rendered or recommended by a non-Network Physician beyond the limits of the original referral unless the care is specifically authorized by your Network Physician and approved in advance.

Self-Referrals

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

- Your personal network physician
- Network Generalists in internal medicine, pediatrics, and family practice
- Network chiropractic and acupuncture services

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

Additionally, some regions allow self-referral to certain specialties:

- California Regions
  - Network specialists in optometry, mental health services, substance use disorder treatment (not including group visits), and obstetrics/gynecology.
  - Network specialists in urology for services related to sexual or reproductive health, such as a vasectomy.

Second Opinions

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

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

What the HAP Covers

This section lists covered medical services and supplies that are frequently used. If you have any questions on whether or not a specific service or supply is covered by the Plan, contact Anthem Blue Cross Member Services at **1-800-964-0530** or Kaiser Permanente Customer Service (**1-800-663-1771 for the Northern California REGION or 1-800-533-1833 for the Southern California Region**).

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

Acupuncture

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

Kaiser HAP members can locate network acupuncture providers by calling American Specialty Health Plans of California at **1-800-678-9133** or visiting its website at www.ashlink.com/ash/kp.

Ambulance Services

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

Emergency Only

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

Non-Emergency

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

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

Cancer Resources

Anthem Cancer Care Support Services Program

Cancer Care Support Services focus on appropriate member identification, provider collaboration and quality focused cancer treatment pathways. Member identification starts with identifying cancer members for referral to Case Management who are at risk for readmission. Patient assessments, facilitation of treatment plans and care coordination are provided by Anthem Case Management in collaboration with not only the member, but also the local care delivery teams.

Case Managers work in conjunction with Anthem's Individualized Care Program when members are identified who may desire palliative care support. A palliative care focus is provided via Social Worker telephonic outreach and/or in the home, where geographically available

Anthem's case management program offers resources that specialize in oncology, and is designed to help members understand what to expect and plan how to move forward with a cancer diagnosis. A nurse specially trained to support oncology patients will be available by phone to:

- Answer your questions
- Explain next steps
- Connect you with resources to support you
- Enroll you in outreach support from the American Cancer Society if you choose

Are you currently undergoing treatment for cancer? If you have questions about benefits or resources, please contact Anthem for referral to a case manager: 1-888-613-1130.

Kaiser Permanente Coordinated Cancer Care

If you're a Kaiser member, your cancer care will be coordinated for you. Kaiser offers specialized cancer centers in regions throughout California—so you can get the right care for your specific type of cancer closer to your home. A dedicated, coordinated cancer team will help you understand treatment options and map out your care.

Kaiser's specialized cancer physicians provide treatment for:

- Bladder cancer
- Acute leukemia
- Brain cancer
- Pediatric brain cancer
- Esophageal cancer
- Gynecologic cancer
- Head and neck cancer
- Liver cancer
- Ocular melanoma
- Pancreatic cancer
- Thyroid cancer
- Radiation oncology
- Pediatric oncology

For more information about Kaiser's cancer resources, contact your doctor.

For details, visit the Cancer Resources details on the Anthem and Kaiser member pages at mypgebenefits.com under Physical Health.

Chiropractic Care

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

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

Kaiser HAP members can locate network chiropractic providers by calling American Specialty Health Plans of California at **1-800-678-9133** or visiting its website at www.ashlink.com/ash/kp.

Hearing Aids

The HAP covers 80% of the allowable cost, subject to deductible, for MEDICALLY NECESSARY hearing aids and related expenses. The plan will cover one hearing aid per ear every three years. The HAP also pays 80% after deductible for cochlear implants for adults and children (age 2 or older), for the following diagnoses: (1) severe to profound bilateral sensorineural hearing loss and severely deficient speech discrimination; or (2) post-lingual deafness in an adult. Hearing aid hardware is limited to one hearing aid per ear every three years.

Home Health Care and Hospice Care

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

For Anthem HAP members, when your doctor recommends either home health or hospice care, you must call Anthem Blue Cross at **1-800-274-7767** to obtain PRE-AUTHORIZATION. A penalty of $300 applies to Anthem HAP members if no pre-authorization is obtained. For Kaiser HAP members, your doctor will obtain pre-authorization at the point of service.

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

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

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

Services in Your Home

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

- Nursing services provided by a registered nurse (R.N.), or a licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.) when under the supervision of an R.N.
- Services of a home health aide.
- Physical, occupational, speech or respiratory therapy and supplies; medical social services; and covered nutritional counseling.
- For a patient formally admitted to a network hospice program: homemaking services; counseling for the patient and family members; up to three days of respite care during a six-month period; and bereavement counseling by a certified social worker who is an employee of the hospice, for up to 12 months after the patient's death. Bereavement counseling benefits are limited to $25 per visit, four visits per family. Counseling may also be covered by Carelon Behavioral Health; see *Mental Health and Substance Use Disorder Coverage* for more information. No limits apply to mental health or substance use disorder services.

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

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

Hospice Facility

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

The following inpatient hospice services are covered:

- Bed, board and general nursing care.
- Medical care provided by other professional providers employed by the facility.
- Hospice facility services and supplies.
- Homemaking services.
- Up to three days of respite care during a six-month period.
- Family counseling related to the patient's illness. Counseling may also be covered by Carelon Behavioral Health; see *Mental Health and Substance Use Disorder Coverage* for more information.
- Bereavement counseling by a certified social worker who is an employee of the hospice, for up to 12 months after the patient's death. Benefits are limited to $25 per visit, four visits per family. Counseling may also be covered by Carelon Behavioral Health; see *Mental Health and Substance Use Disorder Coverage* for more information.

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

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

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

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

Hospital Care — Inpatient

You pay 20% for inpatient HOSPITAL care after meeting the ANNUAL DEDUCTIBLE. For Kaiser HAP members, services must be received at a network facility. For Anthem HAP members, pre-authorization is required for non-emergency care; a $300 penalty applies if pre-authorization is not obtained. When services are performed by a NETWORK PROVIDER, your provider will contact Anthem Blue Cross Medical Management for pre-authorization. When services are performed by a NON-NETWORK PROVIDER, it is your responsibility to contact Anthem Blue Cross Medical Management for pre-authorization or make sure your provider has obtained the necessary pre-authorization.

Covered inpatient hospital services include:

- Room and board in semi-private accommodations; private room if a MEDICALLY NECESSARY covered health service (as determined by standards set by Anthem Blue Cross or Kaiser — see "Covered Health Services."
- SPECIAL CARE UNITS.
- Medical and surgical supplies.
- General private duty nursing care.

- Use of operating and special treatment rooms.
- Anesthesia and its administration by a salaried hospital employee.
- Administration of blood and blood plasma, including the cost of unreplaced blood, blood products and blood processing.
- Hospital ancillary services, including laboratory, cardiology, pathology, radiology and any professional components for such services.
- Routine nursery care for a newborn if the child is enrolled in the HAP.
- Drugs, medicines and oxygen supplied by and used in the hospital.
- Pre-admission testing performed within seven days before hospital admission or outpatient surgery.
- Radiation therapy, chemotherapy, physical therapy, respiratory therapy, and dialysis treatment.
- Short-term speech therapy for correction of speech impairments resulting from illness, injury, surgery, or previous therapeutic processes. Speech therapy due to functional nervous disorders is not covered.
- Physical therapy when furnished by the hospital as a regular service.
- Occupational therapy when furnished by the hospital in conjunction with physical therapy treatments.
- Dental care when a hospital admission is required for dental surgery or extraction of teeth, general anesthesia is required, and a PHYSICIAN certifies that the hospitalization is medically necessary. Any other service related to the dental procedure, such as the dentist's services, is not covered.

Hospital Care — Outpatient

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

Covered outpatient hospital services include:

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

Organ and Tissue Transplants

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

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

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

- Lung transplants
- Liver transplants
- Kidney transplants
- Kidney/pancreas transplants
- Liver/small bowel transplants
- Pancreas transplants
- Small bowel transplants
- Cornea transplants

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

Bone Marrow Donor Search

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

How to Obtain Authorization

PRE-AUTHORIZATION is required for all transplant services:

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

Transportation and Lodging

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

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

Inpatient Prescription Drugs

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

Professional Services

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

- Services of a PHYSICIAN, surgeon or assistant surgeon
- Services of an anesthetist or anesthesiologist in connection with surgery
- Services of a consulting physician when requested by your doctor
- Constant care services rendered by a physician when you are in critical condition
- Physician visits to a HOSPITAL or SKILLED NURSING FACILITY during a covered inpatient confinement
- Visits to your doctor's office or physician house calls for treatment of illness, disease or injury (no charge for first four visits to a primary care physician (PCP))
- Well-baby care up to age two (no charge)
- Radiation therapy
- Outpatient diagnostic X-rays and lab exams, including routine or diagnostic Pap smears and mammograms (no charge for X-rays and lab work coded as preventive care)
- Injections, inoculations and immunizations (no charge for immunizations)
- Physician services in the outpatient department of a hospital, ambulatory surgical facility or short-STAY surgical unit
- Services of a licensed physical therapist for a covered inpatient hospital or skilled nursing facility confinement.
- Certain services from a NON-NETWORK PROVIDER furnished at a network facility may be covered as if they were provided by a network provider as required under federal law.

Diagnostic Screenings Aren't Free

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

Mental Health Care and Substance Use Disorder Treatment

For Anthem HAP members, only MEDICALLY NECESSARY detoxification that is considered to be medical care is covered by the medical provisions administered by Anthem Blue Cross. Mental health care and substance use disorder treatment are covered under the mental health and substance use disorder provisions of the Plan, but are administered by Carelon Behavioral Health.

For Kaiser HAP members, all mental health and substance use disorder treatment benefits are administered by Kaiser Permanente, with the following exceptions:

- Alcohol/substance use disorder treatment and detoxification-inpatient—institutional services: Benefits are administered by Carelon Behavioral Health . Medically necessary detoxification services are also provided by Kaiser.

- Alcohol/substance use disorder treatment inpatient and residential treatment center: Benefits are administered solely by Carelon Behavioral Health.
- Applied Behavioral Analysis (ABA): Benefits are administered by either Carelon Behavioral Health or Kaiser (member's choice).

For more details including coinsurance amount for mental health and substance use disorder treatment, see *Mental Health and Substance Use Disorder Coverage*.

Skilled Nursing Facility

You pay 20% of the NEGOTIATED RATE, subject to deductible, for SKILLED NURSING FACILITY services when you use an Anthem Blue Cross PPO or Kaiser Permanente NETWORK PROVIDER. A HOSPITAL STAY of at least three consecutive days for the same condition is required prior to admission to a SKILLED NURSING FACILITY, and the admission to the skilled nursing facility must be within 30 days of your discharge from the HOSPITAL. PRE-AUTHORIZATION is required. For Anthem HAP members, a penalty of $300 applies if no pre-authorization is obtained.

In addition, Anthem HAP members who use out-of-network providers will be responsible for any charges above the maximum allowed amount. Kaiser HAP members must use network providers to obtain coverage.

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

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

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

Other Covered Medical Services and Supplies

Covered services and supplies include:

- For Anthem HAP Members: *LiveHealth Online* telemedicine services, which can be accessed online or on a mobile device. The HAP provides benefits for covered medical services that are appropriately provided through *Live Health Online*, subject to the terms and conditions of the plan. The Anthem HAP's *LiveHealth Online* benefit does *not* include any other telemedicine health consultations that take place between the patient and the health care provider, or between health care providers, via telephone, facsimile machine, or electronic mail. Kaiser HAP members may use *LiveHealth Online*, but the cost of the service is treated as an out-of-network service.

For Kaiser HAP Members: With Kaiser Permanente's telemedicine feature, Video Visits, along with ongoing features like telephone and call-back appointments, you have more flexibility to meet virtually with a doctor anytime, anywhere—including home and work—for consultation when you're sick, have a rash or even to receive a prescription.

Just go to kp.org/mydoctor/videovisits for additional information about Video Visits or to get started. When meeting with a doctor at work, you must use cell service to connect. Virtual doctor consultations cannot be accessed through PG&E's Wi-Fi.

- Outpatient professional nursing services of a NETWORK PROVIDER that are certified as MEDICALLY NECESSARY covered health services by your PHYSICIAN.
- Services of a licensed nurse midwife working under the direction of a physician (for the Kaiser HAP, both midwife and physician must be network providers). Does not include services of a lay midwife or a doula.

- Medically necessary covered health services of a network provider who is a licensed physical or occupational therapist, when provided by someone other than a close relative or someone who resides in your home, when ordered by a network physician, and when judged by the physician to be subject to significant improvement through such therapy. The therapy must be expected to result in significant, objective, measurable physical improvement in the covered person's condition within two months of the start of the treatment. You pay 10% subject to deductible, for the first five visits and 20%, subject to deductible, for the sixth visit in a calendar year and thereafter. (For purposes of determining coinsurance rates, tallying of the first five visits does not begin until the deductible has been met.) Services may be reviewed by the claims administrator for medical necessity and must be deemed medically necessary to be covered.

  For Anthem HAP members: After 24 visits in a calendar year, you must obtain PRE-AUTHORIZATION for additional visits in the same calendar year.
- Hearing aids and exams are covered at 80%, subject to deductible, as well as exams to determine the need for hearing aids or the need to adjust them. Cochlear implants for adults and children (age 2 or older) are also covered at 20%, subject to deductible, for the following diagnoses: (1) severe to profound bilateral sensorineural hearing loss and severely deficient speech discrimination; or (2) post-lingual deafness in an adult. Hearing aid hardware is limited to one hearing aid per ear every three years.
- For the Kaiser HAP, cochlear implants — criteria for cochlear implant evaluation (required):
  - Pediatric (12–24 months):
    - bilateral profound sensorineural hearing loss
    - hearing aid trial for more than three months
  - Pediatric (2–17 years):
    - bilateral severe–profound sensorineural hearing loss
    - consistent hearing aid use for more than three months
  - Adults:
    - pure tone average (500, 1k, 2k Hz) greater than 70 dBHL, bilaterally
    - word recognition score of less than 40% in better ear
    - hearing aid trial for more than three months, except in the case of a sudden hearing loss
- Non-experimental inpatient drugs and medicines which are approved by the Food and Drug Administration (FDA). Kaiser HAP members may receive coverage for drugs that are on the Kaiser Permanente formulary list.
- Non-human and artificial limbs or eyes, when determined to be a medically necessary covered health service.
- Rental or purchase of durable medical equipment (including prosthetic and orthotic devices, but not foot orthotics, which are excluded from coverage) that is ordered by a physician, approved and determined by Anthem Blue Cross or Kaiser to be a medically necessary covered health service, and is to be used solely by the patient. For Anthem HAP members, pre-authorization is required for the purchase or cumulative rental of durable medical equipment for which the total price is equal to or greater than $1,000; there will be a $300 penalty if pre-authorization is not obtained by Anthem HAP members. In addition, if an item is rented, the rental price for the entire rental period cannot be more than the purchase price. The rented item must be returned if the member switches plans. Necessary repairs and maintenance of purchased equipment are also covered if not provided under a manufacturer's warranty or purchase agreement.
- Wigs and toupees for alopecia areata or alopecia resulting from chemotherapy or radiation therapy; limit of one wig or toupee every two years.
- For Anthem HAP members: Initial pair of eyeglasses or contact lenses prescribed by a doctor after eye surgery; For Kaiser HAP members: Contact lenses are provided after aphakia/aniridia surgery only.
- Eyeglasses or lenses when needed to replace loss of the natural lens. For Kaiser HAP members, this benefit is available only for children from birth to age 9, with a limit of six contact lenses per eye per calendar year.
- For Kaiser HAP members: Lenses to treat the absence of eye iris. Limit of two sets of lenses every 12 months.

- Rental of dialysis equipment and all medically necessary covered health services and supplies required for dialysis treatment.
- Oxygen, including its administration.
- Short-term speech therapy services rendered by a network certified speech therapist when required due to surgery, illness, injury, or previous therapeutic processes, when ordered by a network physician, and when judged by the physician to be subject to significant improvement through such therapy. Speech therapy due to functional nervous disorders is not covered. The therapy must be expected to result in significant, objective, measurable improvement in the covered person's condition within two months of the start of the treatment. You pay 10%, subject to deductible, for the first five visits and 20%, subject to deductible, for the sixth visit in a calendar year and thereafter. (For purposes of determining coinsurance rates, tallying of the first five visits does not begin until the deductible has been met.) Services will be reviewed by the claims administrator for medical necessity and must be deemed medically necessary to be covered. In addition, after 24 visits in a calendar year, Anthem HAP members must obtain pre-authorization for additional visits in the same calendar year.
- For Anthem HAP members, mental health and substance use disorder treatment benefits are covered under the Plan, but these benefits are available through Carelon Behavioral Health rather than Anthem Blue Cross. For Kaiser HAP members, mental health and substance use disorder benefits are administered by both Kaiser and Carelon Behavioral Health, depending on the type of service. See *Mental Health and Substance Use Disorder Coverage* for more information.
- Applied Behavioral Analysis (ABA) is covered under the Plan. For Anthem HAP members, benefits for ABA are available through Carelon Behavioral Health. For Kaiser HAP members, you have the option to receive ABA benefits through Carelon Behavioral Health or Kaiser. See *Mental Health and Substance Use Disorder Coverage* for more information.
- Diabetes self-management education programs.
- Surgery to change an individual's appearance when the purpose is:
  - to correct the result of an ACCIDENTAL INJURY; or
  - to treat a condition, including a birth defect, that impairs the function of a body organ.
- Diagnostic procedures for the prenatal diagnosis of genetic disorders of the fetus when authorized by a participating physician in the case of high-risk pregnancy.
- Surgical treatment of morbid obesity when authorized by a network physician and approved by Anthem Blue Cross or Kaiser Permanente, as applicable, when surgical treatment of morbid obesity is necessary to treat another life-threatening condition involving morbid obesity, and when it has been documented that non-surgical treatments of the morbid obesity have failed. For bariatric surgery, there is a transportation and lodging benefit of up to $3,000 available (pre-authorization required; contact your plan administrator for more information).
- INFERTILITY treatments, up to a lifetime maximum of $7,000 combined. The benefit includes, but is not limited to, in vitro fertilization services, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and artificial insemination/microinjection techniques. Services provided must be considered safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications.
- Coverage for routine mammographies (given as preventative measures to detect problems when a physician does not have a specific reason to suspect a medical problem), in accordance with Anthem Blue Cross or Kaiser's standard administrative policies. Diagnostic mammographies, which are given when there is a suspected problem, are covered as well.
- Gender-affirming surgery, if the surgery meets all the criteria for being deemed medically necessary by Anthem Blue Cross or Kaiser Permanente, as applicable. There is a transportation and lodging benefit of up to $3,000 available (pre-authorization required; contact your plan administrator for more information).
- Routine services during a qualified clinical trial for cancer or another life-threatening condition will be covered to the same extent as those services for members who are not enrolled in clinical trials. Clinical trial drugs are

not a covered benefit under HAP since they are paid for by the pharmaceutical company sponsoring the trial. Investigational items or services related to the clinical trial, items and services provided solely for data collection and analysis and that are not used in the direct clinical management of the patient, and services which are clearly inconsistent with widely accepted and established standards of care for the patient's diagnosis are not covered.

Women's Health and Cancer Rights Act

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

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

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

Newborns' and Mothers' Health Protection

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

What the HAP Doesn't Cover

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

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

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

- Services that do not meet the definition of covered health services.
- Any services or supplies that are considered to be "experimental" or "investigational," as determined solely by Anthem Blue Cross or Kaiser Permanente. EXPERIMENTAL PROCEDURES are defined as procedures that are mainly limited to laboratory and/or animal research. Investigational services include any treatment, therapy, procedure, drug, facility, equipment, device or supply that is not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of an illness, injury or condition. Investigational services also include those which require approval by the federal government or any agency thereof, or by any state governmental agency, prior to use, and where such approval has not been granted at the time the services were rendered.
- Speech therapy that is not determined to be a medically necessary covered health service, as determined solely by Anthem Blue Cross or Kaiser Permanente. An additional medically necessary review is required after the first 24 visits in a calendar year.
- Physical and/or occupational therapy that is not determined to be a medically necessary covered health service, as determined solely by Anthem Blue Cross or Kaiser Permanente. An additional medically necessary review is required after the first 24 visits in a calendar year.
- Massage therapy, if performed by a massage therapist, or any services performed by a massage therapist who is not also a PHYSICIAN or other approved health care provider (see *Glossary*). However, massage therapy performed by a physical therapist or chiropractor is covered, if deemed to be medically necessary by Anthem Blue Cross or Kaiser Permanente.
- Any services or supplies for learning disabilities, behavioral problems, intellectual disability, or hospitalization for environmental change except for Applied Behavioral Analysis (ABA) or speech/occupational/physical therapy rendered in association with autistic spectrum disorder. Services and supplies primarily for the treatment of mental, behavioral, psychoneurotic, personality, or substance usedisorders are generally not covered as medical services by Anthem, except to the extent that certain services (e.g., speech, physical, occupational therapy, or nutritional counseling) are otherwise eligible for coverage under the Plan's medical benefits. Coverage for primary treatment of such conditions may be covered elsewhere by the Plan under the Mental Health and Substance Use Disorder treatment provisions administered by Carelon Behavioral Health.
- Any services or supplies furnished in connection with foot care, unless they are determined to be medically necessary covered health services and ordered by your attending physician.
- Orthopedic shoes (except when joined to braces) or shoe inserts, such as orthotics, even if recommended by your physician, unless for diabetes-related conditions.
- Services or supplies that are not determined to be covered health services, including any confinement or treatment given in connection with a service or supply that is not covered under the Plan.
- Exercise programs, exercise monitoring, exercise equipment, and health spa programs. Outpatient dietary consultations are also excluded unless medically necessary.
- Services or supplies primarily for weight reduction or treatment of obesity, unless they are determined to be medically necessary covered health services and authorized by a NETWORK PROVIDER and Anthem Blue Cross or Kaiser Permanente. This exclusion will not apply to surgical treatment involving morbid obesity if:
  - surgical treatment of morbid obesity is necessary to treat another life-threatening condition involving morbid obesity, and
  - it has been documented that non-surgical treatments of the morbid obesity have failed, and
  - surgical treatment has been approved by Anthem Blue Cross or Kaiser Permanente.
- Heating pads and thermometers, and other over-the-counter products.
- Devices and computers to assist in communication and speech.
- Air purifiers, air conditioners and humidifiers.
- Supplies for comfort, hygiene or beautification.

- Services and supplies furnished in connection with injury or disease arising out of, or in the course of, any work for wage or profit (whether or not with the employer) if such injury or disease is covered by any Workers' Compensation law, occupational disease law or similar law. The HAP claims administrator will provide services and supplies in connection with such injury or disease but will be entitled to reimbursement for them in accordance with rules set out in The Pacific Gas and Electric Company Health Care Plan for Active Employees Plan Document.
- Treatment for conditions caused by war or aggression, declared or undeclared, or international armed conflict.
- Services or supplies to the extent furnished by any law or government, unless required by law.
- Benefits provided under the "Medicare" section of the Social Security Act.
- Services and supplies for which coverage is available under any other Company-sponsored health plan or benefit program.
- Alternative treatments such as acupressure, aromatherapy, hypnotism, rolfing and other forms of alternative treatment, as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Charges for failure to keep a scheduled appointment, transfer of medical records, and other similar charges for which no medical treatment or services have been provided.
- Services that are educational in nature, unless specifically authorized by Anthem Blue Cross or Kaiser.
- Except as otherwise provided herein for preventive and well-care exams and tests, any services in connection with routine physical exams or medical exams not connected with the primary purpose of the discovery of a medical condition, disease or illness leading to treatment, such as a pre-employment medical exam or a team sports exam.
- Benefits provided under the extension of a benefits provision of other insurance policies, benefit plans, or health plan contracts.

See "Reductions/Exclusions for Duplicate Coverage."

Mental Health and Substance Use Disorder Coverage

The Company provides mental health and substance use disorder treatment for you and your eligible dependents.

The way you receive mental health and substance use disorder benefits ("behavioral health coverage") depends on which Health Account Plan (HAP) claims administrator you have selected. You and your eligible dependents are automatically enrolled in the appropriate program when you enroll in the HAP. Carelon Behavioral Health, a behavioral health managed care company, is the primary administrator of your mental health and substance use disorder coverage if you are in the Anthem HAP. If you are in the Kaiser HAP, Kaiser Permanente will be your primary administrator of your mental health and substance use disorder coverage (see *What the HAP Covers* for additional information).

EAP Coverage Is Separate

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

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

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

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

How Benefits Are Provided

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

If you are in the Anthem HAP

Mental health and substance use disorder treatment is administered by Carelon Behavioral Health. Coverage begins on the same date as your medical plan coverage. You and your dependents may also seek services through the Employee Assistance Program (EAP), which is available to all active employees, their spouses/registered domestic partners, their eligible dependents, and their household members. For details, see *Employee Assistance Program (EAP)*.

If you are in the Kaiser HAP

All mental health services, including inpatient and alternate levels of care, structured outpatient or partial hospitalization, and outpatient substance use disorder treatment are provided directly through Kaiser. Coverage begins on the same date as your medical plan coverage. You and your dependents may also seek services through the Employee Assistance Program (EAP), which is available to all active employees, their spouses/registered domestic partners, their eligible dependents, and their household members. For details, see the *Employee Assistance Program (EAP)*.

For substance use disorder treatment:

- Kaiser Permanente provides outpatient detoxification services, intensive or structured outpatient services and partial hospitalization for substance use disorder treatment.
- Carelon Behavioral Health provides detoxification, inpatient or residential substance use disorder treatment. In order to receive benefits from the Carelon Behavioral Health program, eligible members must notify Carelon Behavioral Health within 48 hours of an admission or a $300 penalty will be applied. Coverage begins on the same date as your medical plan coverage.

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

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

In order to receive benefits from the Carelon Behavioral Health program for any alternate levels of care (including partial hospitalization, residential, intensive and structured outpatient care), eligible HAP members must notify Carelon Behavioral Health within 48 hours of an admission. Carelon Behavioral Health is also the administrator of the Employee Assistance Program (EAP). For details, see *Employee Assistance Program (EAP)*.

Deductibles, Limits, and Coinsurance

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

- For Anthem HAP members, benefits are based on ELIGIBLE EXPENSES. See "Eligible Expenses."
- For Kaiser HAP members, benefits are based on eligible charges. See "Eligible Expenses."

If You Are in the Anthem HAP

Facility-Based Outpatient Mental Health Treatment (Institutional & Professional, Intensive Outpatient, Partial Hospitalization)	▪ You pay 10% of covered charges, no deductible ▪ Requires authorization by Carelon Behavioral Health ▪ Applies to combined out-of-pocket maximum	Carelon Behavioral Health
Outpatient Mental Health Treatment	▪ You pay 10% of covered charges, no deductible ▪ Applies to combined out-of-pocket maximum	Carelon Behavioral Health
Inpatient Mental Health Treatment (Institutional, Acute Inpatient, Residential Treatment Center)	▪ You pay 20% of covered charges, after medical plan deductible ▪ $300 penalty if you fail to notify Carelon Behavioral Health within 48 hours ▪ Covers emergency room services at 80% after deductible, for services coded with Mental Health and Substance Use Disorder (MHSUD) code ▪ No limit on number of stays ▪ Applies to combined out-of-pocket maximum	Carelon Behavioral Health
Autism Applied Behavior Analysis (ABA)	▪ Fully covered (no deductible) ▪ Requires authorization by Carelon Behavioral Health	Carelon Behavioral Health
Facility-Based Outpatient Substance Use Disorder Treatment (Institutional & Professional, Intensive Outpatient, Partial Hospitalization,)	▪ You pay 10% of covered charges, no deductible ▪ Requires authorization by Carelon Behavioral Health ▪ No visit limit ▪ Applies to combined out-of-pocket maximum	Carelon Behavioral Health
Outpatient Substance Use Disorder Treatment	▪ You pay 10% of covered charges, no deductible ▪ Applies to combined out-of-pocket maximum	Carelon Behavioral Health

Inpatient Substance Use Disorder (Detoxification, Acute Inpatient, and Residential Treatment)	▪ You pay 20% of covered charges, after medical plan deductible ▪ $300 penalty if you fail to notify Carelon Behavioral Health within 48 hours ▪ Covers emergency room services at 80% after deductible, for services coded with Mental Health and Substance Use Disorder (MHSUD) code. ▪ No limit on number of stays ▪ Applies to combined out-of-pocket maximum	Carelon Behavioral Health
Mandated treatment for DOT, NRC-, and OSHA-certified crane operators, or PG&E Self-Identification Program for Alcohol/Substance Use Disorder Treatment	▪ Fully covered (no deductible) ▪ Requires authorization by Carelon Behavioral Health or an onsite EAP counselor	Carelon Behavioral Health

If you are in the Kaiser HAP

Outpatient Mental Health Treatment **(Institutional & Professional, Intensive Outpatient, Day Treatment)**	▪ You pay 10% of covered charges, no deductible ▪ Requires authorization by Kaiser Permanente ▪ Applies to combined out-of-pocket maximum	Kaiser Permanente
Outpatient Mental Health (Office)	▪ You pay 10% of covered charges, no deductible ▪ Applies to combined out-of-pocket maximum	Kaiser Permanente
Inpatient Mental Health Treatment **(Institutional, Residential Treatment Center)**	▪ You pay 20% of covered charges, subject to deductible ▪ Requires authorization by Kaiser Permanente ▪ Applies to combined out-of-pocket maximum	Kaiser Permanente
Autism Applied Behavior Analysis (ABA)	▪ Fully covered (no deductible) ▪ Requires authorization by plan	Kaiser Permanente or Carelon Behavioral Health
Outpatient Substance Use Disorder (Outpatient, Day Treatment, and Intensive Outpatient)	▪ You pay 10% of covered charges, no deductible ▪ No visit limit ▪ Applies to combined out-of-pocket maximum	Kaiser Permanente

Inpatient Substance Use Disorder (Detoxification, Acute Inpatient and Residential Treatment)	▪ You pay 20% of covered charges, subject to deductible ▪ $300 penalty if you fail to notify Carelon Behavioral Health within 48 hours ▪ Covers emergency room services at 80% after deductible, for services coded with Mental Health and Substance Use Disorder (MHSUD) code. ▪ Provides detoxification, inpatient, and residential treatment ▪ No limit on number of stays ▪ Applies to combined out-of-pocket maximum	**For Inpatient Detoxification:** ▪ May use Carelon Behavioral Health or Kaiser **For all other Inpatient/Residential Treatment:** ▪ Carelon Behavioral Health network only, not Kaiser.
Mandated treatment for DOT, NRC and OSHA-certified crane operators, or PG&E Self-Identification Program for Alcohol/Substance Use Disorder Treatment	▪ Fully covered (no deductible) ▪ Requires authorization by Carelon Behavioral Health or an onsite EAP counselor	▪ Carelon Behavioral Health – inpatient treatment ▪ Kaiser Permanente – outpatient treatment

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

Please note that Carelon Behavioral Health is the Claims Administrator only for the mental health and substance use disorder benefits that are included under the Anthem HAP and for the Detox, Residential and Acute Inpatient substance use disorder treatment included under the Kaiser HAP.

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

How to Obtain Benefits

If you are in the Anthem HAP, you must obtain authorization from Carelon Behavioral Health or an onsite EAP counselor for all mental health/substance use disorder inpatient, alternative levels of care, (Intensive Outpatient, Residential Treatment Program, Partial Hospitalization) and outpatient (non-Office).

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

- Carelon Behavioral Health by calling 1-888-445-4436 to speak with a Carelon Behavioral Health care manager who will coordinate your case; or
- An onsite EAP counselor during normal business hours (please see *Employee Assistance Program (EAP)*.

Carelon Behavioral Health care managers are available 24 hours a day, 7 days a week, to assist you. Your case will be confidential, except as otherwise provided by law or as noted in any paperwork you may complete.

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

For outpatient treatment, you may browse through Carelon Behavioral Health's network of providers yourself by accessing Carelon Behavioral Health's website for PG&E members at www.carelonbh.com/pge. You can use various selection criteria, such as geographic location and provider's specialty, to help find an appropriate provider. Should you need assistance in establishing an appointment, the Carelon Behavioral Health Access Team can assist you. Call the number and let the care manager know you need help.

If you are in the Kaiser HAP, you must obtain a referral from a network provider for mental health or substance use disorder services.

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

In Case of Emergency

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

If you are in the Anthem HAP, authorization is not required for emergency room treatment. However, if you are admitted to the hospital, you or your provider must contact Carelon Behavioral Health within 48 hours of the admission. Failure to properly notify for any higher level of care (that is, inpatient care, partial hospitalization, residential treatment, intensive or structured outpatient care), will result in a $300 penalty. This penalty applies to Mental Health and Substance Use Disorder treatment provided by either network or NON-NETWORK PROVIDERS.

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

What Is Covered Under the HAP

Eligible Expenses

For Anthem HAP members, ELIGIBLE EXPENSES are:

- expenses for covered health services that are covered by the Plan,
- those expenses that Carelon Behavioral Health considers MEDICALLY NECESSARY for diagnosis or treatment; and
- those that do not exceed the "maximum allowed amount", as determined by Carelon Behavioral Health. You generally will be charged amounts that are higher than the negotiated rate charged by a network provider and will be responsible for the portion of those fees that are over the maximum allowed amount. You may also be responsible for any ineligible expenses or even the entire bill. You should discuss this with your provider, as these amounts can be substantial.

Eligible Charges

For Kaiser HAP members, ELIGIBLE EXPENSES are:

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

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

Benefits

Mental health expenses covered under the program include:

- Inpatient treatment;
- Residential Treatment centers;
- Applied Behavioral Analysis (ABA)
- Partial Hospitalization; and
- Outpatient treatment (Institutional, Professional, and Intensive).

Substance use disorder treatment expenses covered under the program include:

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

You receive benefits only if:

- your treatment is medically necessary (see "Medically Necessary Services") and is approved by the appropriate party, as necessary: a Carelon Behavioral Health care manager or one of the Company's on-site EAP counselors, or by Kaiser Permanente, whichever is applicable; and
- the primary diagnosis is a mental health condition or substance use disorder.

All inpatient and alternative level of care benefits require authorization from Carelon Behavioral Health or Kaiser Permanente, as applicable.

Mental Health

Inpatient

For inpatient mental health treatment, after your HAP's deductible has been satisfied, you pay 20% for authorized treatment. Authorization is required from Carelon Behavioral Health Kaiser Permanente, as applicable.

Outpatient

For outpatient mental health care through Carelon Behavioral Health or Kaiser Permanente, as applicable, you pay 10%. No deductible is applied. Authorization is required from Kaiser, as applicable.

Substance Use Disorder Treatment

Authorization for inpatient or Alternate Levels of Care (partial hospitalization, residential treatment, and intensive or structured outpatient care) is required. Kaiser HAP members receive any outpatient substance use disorder care, partial hospitalization or structured outpatient levels of care services through Kaiser Permanente, not through Carelon Behavioral Health. They are eligible to receive inpatient, residential and medically necessary inpatient detoxification care through the program administered by Carelon Behavioral Health.

Inpatient

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

Alternate Levels of Care

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

Outpatient

For outpatient substance use disorder care through Carelon Behavioral Health or Kaiser Permanente, as applicable, you pay 10%. No deductible is applied. There is no maximum on the number of visits.

Medical Management and Authorization Programs

Benefits are provided only for MEDICALLY NECESSARY and appropriate services. (See *How the HAP Works*.)

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

For Anthem HAP Members

Authorization

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

Failure to obtain authorization for a confinement or treatment for any higher level of care (e.g., inpatient care, partial hospitalization, residential treatment, intensive or structured outpatient care) could result in the services or treatment not being covered. For this reason, it is important to obtain authorization prior to receiving services or treatment. In addition to the services potentially not being covered, there will be a $300 penalty applied if PRE-AUTHORIZATION is not obtained within 48 hours of confinement or treatment. This penalty applies to Mental Health and Substance Use Disorder treatment provided by either network or non-network providers.

Utilization Review

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

Concurrent Review

The concurrent review process provides authorization for a determined time period depending on the level of care. Prior to the end of the authorization, the provider must contact Carelon Behavioral Health to provide updated information on which Carelon Behavioral Health can base its decision to authorize or deny the treatment. Failure to obtain the authorization will result in the claim being denied. Network providers will contact Carelon Behavioral Health, but non-network providers may need to be reminded to do so. Remember, you are responsible for the payment of services rendered until there is an authorization provided by Carelon Behavioral Health.

Retroactive Review

The retroactive review process can be used in circumstances in which authorization was not established prior to the services being provided. In that case, you can request the retroactive review and provide written authorization to release the clinical records to Carelon Behavioral Health. Once the records are received, Carelon Behavioral

Health will review the information and make a determination as to whether medical necessity has been established. If medical necessity is not established, then the claims will be denied. If medical necessity is established, the claims will be paid according to the benefit plan provisions. There will be a $300 penalty applied if PRE-AUTHORIZATION was not obtained.

For Kaiser HAP Members

Utilization Review Program

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

Pre-Authorization

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

If you are in the Kaiser HAP and are receiving care from Carelon Behavioral Health, please refer to the instructions for Anthem HAP members above.

Medically Necessary

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

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (ICD-10 or DSM) that threatens life, causes pain or suffering, or results in illness or infirmity.
- Expected to improve an individual's condition or level of functioning.
- Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of the patient's needs.
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance use disorder care professionals or publications.
- Reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available.
- Not primarily intended for the convenience of the recipient, caretaker, or provider.
- No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

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

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

- Treatment programs for which the primary diagnosis is not a mental health condition or substance use disorder (although services for other diagnoses may be covered under the medical provisions of the Plan).
- Treatment programs which are not certified as MEDICALLY NECESSARY.
- Services for growth/personal exploration or learning disabilities, except for Applied Behavioral Analysis (ABA).
- Mental health and substance use disorder treatment in a group home or halfway house.
- Treatment that does not meet the national standards established by mental health or substance use disorder treatment professionals, or treatment that is deemed to be experimental.

- Court-ordered testing and treatment (unless otherwise covered and medically necessary).
- Services or supplies rendered or furnished before the patient became covered by the Program or after the patient's coverage terminated.
- Treatment for tobacco addiction.
- Ancillary services for vocational rehabilitation, behavioral training and employment counseling.
- Medical detoxification that must be provided in an acute medical unit of a HOSPITAL. (This expense is covered under the medical provisions of the HAP.)
- For the Anthem HAP:
  - Charges in excess of maximum allowed amount fees, or NEGOTIATED RATES in the case of a NETWORK PROVIDER (see *How the HAP Works* and the definition of "ELIGIBLE EXPENSES" under *Glossary*);
  - Hypnotherapy;
  - Second opinions (inpatient or outpatient);
  - Outpatient services rendered outside of the United States are not covered unless urgent or emergent. Inpatient services rendered outside of the United States are not covered under any circumstances.
- For the Kaiser HAP, charges in excess of eligible charges, as determined by Kaiser (see *How the HAP Works* and the definition of "eligible charges" under *Glossary*).
- Outpatient or take-home prescription drugs and medicines, outpatient diagnostic laboratory tests, and ambulance transportation for covered conditions. (These expenses may be covered under the medical or prescription drug provisions of the HAP.)
- Any conditions for which benefits are recoverable under Workers' Compensation or any similar law.
- Treatment of a family member other than as a patient (unless it is part of an approved treatment plan for the patient).
- Custodial care for a mental health condition. Custodial care is defined as care rendered to a patient who:
  - is disabled mentally or physically, and such disability is expected to continue and to be prolonged; and
  - requires a protected, monitored and controlled environment, whether in an institution or in the home; and
  - requires assistance to support the essentials of daily living; and
  - is not under active and specific medical/surgical or psychiatric treatment which will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

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

More About Mental Health and Substance Use Disorder Treatment Benefits

Benefits Under Other Plans

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

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

Refer to "If You Have Other Coverage" for more information on coordination of benefits.

Third-Party Exclusion

The HAP contains an exclusion for any injury, illness or other condition for which a third party may be liable or legally responsible by reason of negligence, intentional action, or breach of legal obligation. These exclusions, limitations, and conditions are described under “Subrogation and Reimbursement.”

Claims and Appeals Process

For information on how to file a claim for benefits with Carelon Behavioral Health or Kaiser for mental health or substance use disorder coverage, please see “Filing a Claim.”

Prescription Drug Coverage

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

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

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

Plan Benefits

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

Plan Benefits for Anthem HAP Members

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

Retail Drug Purchases	**First three 30-day supplies** at a participating pharmacy: ▪ You pay 15% for generic drugs, 25% for brand name drugs. **Fourth fill and beyond** of drugs **not on** mandatory mail-order drug list: ▪ You pay 15% for generic drugs, 25% for brand-name drugs. **Fourth fill and beyond** of drugs **on** mandatory mail-order drug list: ▪ No coverage for additional fills except through Express Scripts mail-order program. Through mail order, you're responsible for 10% of covered charges for generic; 20% for brand. ▪ Note: You need to use mail-order to get coverage for maintenance drugs. Generic Incentive Provision and Step Therapy Provision apply. Preventive drugs on the ACA preventive services list are provided at $0 cost share.
Mail-Order Purchases	You pay 10% for generic drugs and 20% for brand-name drugs, up to a 90-day supply Generic Incentive Provision and Step Therapy Provision apply
Generic Incentive Provision	Member is responsible for paying the difference between the price of a generic drug and a brand-name drug, plus coinsurance, if purchasing a brand-name drug when a generic version is available. Please note that any generic-brand price differential you pay is a non-covered expense and, thus, does not count towards your ANNUAL DEDUCTIBLE or out-of-pocket maximum.
Step Therapy Provision	To ensure members have access to clinically appropriate medications, the Plan requires that members try generic medication or lower-cost brand-name alternatives first, instead of higher-cost brand-name drugs to the extent permitted by applicable law. Express Scripts will review and approve exceptions if brand-name drugs are required. Members may request such a review by submitting an appeal directly to Express Scripts.

Annual Deductible	Annual deductible coordinates with medical plan and mental health/substance use disorder coverage; $1,000/individual, $2,000/family maximum. Deductible applies for all prescription drugs, except for preventive medications/devices on the HAP free drug list.
Annual Out-of-Pocket Maximum	▪ $2,400 per person, $4,800 per family. ▪ Out-of-pocket maximum coordinates with the medical plan and mental health/Substance Use Disorder coverage. Covers both retail drugs and mail-order drugs. Non-covered expenses, such as generic-brand price differentials and other penalties, are not ELIGIBLE EXPENSES and will not count toward your annual deductible or out-of-pocket maximum, nor will these expenses be covered by the Plan after your annual out-of-pocket maximum is met.
Lifetime Maximum	None
Preventive Drugs and Devices	▪ Preventive medications on the HAP Free Drug List are fully covered (no deductible) at mail order only. Preventive drugs on the ACA preventive services list are provided at $0 cost share. ▪ Contraceptive devices (including birth control) indicated on the HAP Free Drug List are considered preventive and are fully covered (no deductible) at mail order. Also available at retail pharmacies at designated retail coinsurance.
Infertility, Memory Enhancement and Sexual Dysfunction Drugs	▪ You pay 50% for both retail and mail-order plans, unless MEDICALLY NECESSARY. ▪ Medically necessary drugs are covered at standard reimbursement rates. ▪ Generic Incentive Provision applies.

Express Scripts has NEGOTIATED RATES with many retail pharmacies. Benefits for prescription drugs purchased at these pharmacies are paid based on these negotiated rates. The pharmacies that Express Scripts has negotiated with are called "participating" pharmacies. To receive the greatest benefit on retail prescriptions, participating pharmacies should be used. A directory of participating pharmacies can be obtained by calling **Express Scripts Member Services at 1-800-718-6590** or by visiting Express Scripts' website at express-scripts.com. You also can use the easy mail-order program for your maintenance drugs.

Manufacturer rebates are earned upon participant purchase of certain prescription drugs. The value of these rebates is based on the contract that Pacific Gas and Electric Company, as Plan sponsor, has with Express Scripts. These rebates are received from Express Scripts approximately six months after the purchase of a drug.

Plan Benefits for Kaiser HAP Members

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

Retail Drug Purchases	You pay 15% for generic drugs and 25% for brand-name drugs, for up to a 100-day supply Preventive drugs on the HAP Free Drug List are fully covered (no deductible)
Mail-Order Purchases	You pay 10% for generic drugs and 20% for brand-name drugs, for up to a 100-day supply
Annual Deductible	ANNUAL DEDUCTIBLE coordinates with medical plan; $1,000/individual, $2,000/family maximum. Deductible applies for all prescription drugs, except for preventive medications and devices on the HAP Free Drug List
Annual Out-of-Pocket Maximum	▪ $2,400 per person, $4,800 per family ▪ Out-of-pocket maximum coordinates with the medical and mental health/substance use disorder coverage. Covers both retail drugs and mail-order drugs. Non-covered expenses are not eligible charges and will not count toward your annual deductible or out-of-pocket maximum, nor will these expenses be covered by the Plan after your annual out-of-pocket maximum is met.
Lifetime Maximum	None
Preventive Drugs and Devices	▪ Preventive medications on the HAP Free Drug List are fully covered (no deductible) at either Kaiser Permanente pharmacies or Kaiser Permanente mail-order ▪ Contraceptive devices (including birth control) indicated on the HAP Free Drug List are considered preventive and are fully covered (no deductible)
Infertility, Memory Enhancement and Sexual Dysfunction Drugs	▪ You pay 50% for both retail and mail-order plans
Step Therapy	If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

Generic Incentive Provision – Anthem HAP

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

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

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

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

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

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

If a generic prescription causes issues or is found to not be as effective, and a brand name drug is required, Anthem HAP members may file an appeal with Express Scripts. If appeal is approved, you may fill your prescription with the brand name drug, but you will be required to pay the full brand name price.

Step Therapy Provision – Anthem HAP

For Anthem HAP members, the plan has a "Step Therapy Provision." To ensure members have access to clinically appropriate medications, the plan requires that members try generic medication or lower-cost brand-name alternatives first, instead of higher-cost brand-name drugs. Express Scripts will review and approve exceptions if brand-name drugs are required. Members may request such a review by submitting an appeal directly to Express Scripts.

Eligibility

For Anthem HAP members, employees and their eligible dependents are eligible for the prescription drug coverage administered by Express Scripts.

For Kaiser HAP members, employees and their eligible dependents are eligible for the prescription drug coverage administered by Kaiser Permanente.

How the Plan Works

For Anthem Blue Cross HAP members

If you are in the Anthem HAP, the Retail Pharmacy Service, managed by Express Scripts, helps you pay part of the cost of retail prescription drugs — that is, drugs that you purchase at local pharmacies.

When you enroll in the Anthem HAP, you are issued a member identification card by Express Scripts. Go to any participating pharmacy, present your card identifying you as an Express Scripts member, and pay the appropriate coinsurance. You may also go to a non-participating pharmacy; however, you will be responsible for paying the entire cost of the prescription upfront and then filing a claim form for reimbursement. It is likely that a non-participating pharmacy will charge more than the pre-NEGOTIATED RATEs of a participating pharmacy. Reimbursement is based on the amount a participating pharmacy would have charged, minus the coinsurance amount. You may call 1-800-718-6590 or go to express-scripts.com to verify pharmacy participation.

Maintenance drugs (i.e., those you use on an ongoing basis) purchased at a participating retail pharmacy will be reimbursed for up to three 30-day supplies at 85% for generic drugs and 75% for brand-name drugs. There is no coverage at retail for refills of most maintenance drugs beyond a 90-day supply limit (three 30-day fills of each prescription). For example, members will pay 15% for an initial 30-day supply of a generic maintenance drug as well as for two 30-day generic refills at a retail pharmacy. If the member requests a fourth prescription of the same maintenance drug at a retail pharmacy, the reimbursement rate will drop to 0% and the member has to pay 100% of the cost. Therefore, it is suggested that members use Express Scripts' mail-order pharmacy for refills of maintenance drugs beyond a 90-day supply.

Here's how to use mail order for maintenance drugs:

- Ask your PHYSICIAN for two separate prescriptions: one prescription for a 30-day supply (to be filled at your local retail pharmacy) and one prescription for a 90-day supply (to be filled through Express Scripts' mail-order pharmacy).
- Have your 30-day prescription filled immediately at your retail pharmacy. About two weeks later (after you have used up half of your 30-day supply and have decided to continue taking this particular prescription drug), submit your 90-day prescription to Express Scripts' mail-order pharmacy. This will allow a 14-day turn-around time for your mail-order prescription to be delivered to your home. Express Scripts will not issue your 90-day supply if you send your order in any sooner than this because it will still be too early to fill the prescription.

Express Scripts Mail-Order Pharmacy

Express Scripts' mail-order pharmacy is available to employees and their eligible dependents who are enrolled in the HAP administered by Anthem Blue Cross.

This program enables you to purchase your maintenance medications, often at a savings, while having them delivered directly to your home via U.S. mail. "Maintenance" medications are those drugs that you take on a long-term or an on-going basis — in other words, those drugs that you know you'll need and can order in advance. Some examples of conditions for which maintenance medications are prescribed are high blood pressure, high cholesterol, heart disorders, diabetes, arthritis and stomach ulcers.

How Express Scripts' Mail-Order Pharmacy Works

With Express Scripts' mail-order pharmacy, you may obtain up to a 90-day supply of medication for each prescription. You pay 10% of the cost for each prescription filled with generic drugs, and 20% for those filled with brand-name drugs. If you elect to use a brand-name drug when a generic drug is available, you will be responsible for paying the difference between the price of the generic drug and the brand-name drug, plus coinsurance, as described under Generic Incentive Provision.

Patient Profile

When you order from Express Scripts' mail-order pharmacy for the first time, you will need to complete the mail-order form and the Express Scripts "Health, Allergy & Medication Questionnaire" (HMQ). Complete both forms and mail them, along with your original prescription, in an envelope addressed to:

Express Scripts
P.O. Box 747000
Cincinnati, Ohio 45274-7000

The Express Scripts mail-order form, the HMQ, and mail-order envelopes are available by calling **Express Scripts Member Services at 1-800-718-6590**. You may also download the mail-order form and HMQ from Express Scripts' website at express-scripts.com (scroll to the bottom of the Home page and click on Health & Benefits

Information > Print & Request Forms & Cards) or at mypgebenefits.com (click on Physical Health > Medical Anthem Member > Filling Prescriptions > Filling Prescriptions by Mail).

The purpose of the HMQ is to alert the pharmacists who are filling your prescriptions of any allergies or medical conditions that might be affected by the prescriptions you are ordering, in an effort to prevent any potentially harmful drug reactions. All information in the HMQ is confidential.

Paying Your Coinsurance

You can request that Express Scripts bill you for your coinsurance, up to $150, or you can instruct Express Scripts to bill your credit card or debit card (e.g., VISA, MasterCard, your Optum Financial health payment or personal debit card). Alternatively, you can submit payment in advance. To do so, you will need to call Express Scripts to find out the amount of your coinsurance. Then send your personal check or money order, along with your original prescription, when you send in your order.

Obtaining Your Medications

Express Scripts will mail your medications directly to your home. You will receive your medication within 14 days from the date on which Express Scripts receives your order. If you need your prescription sooner, just let Express Scripts know and, for an extra charge, your prescription will be sent via UPS or Federal Express.

Whenever possible, your prescription will be filled with a generic drug that meets the same standards as the brand name, unless your physician specifies otherwise.

Express Scripts' specialty pharmacy, Accredo Health Group, handles prescriptions for complex conditions such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis, which are treated with specialty medications. Specialty medications are typically injectable medications administered either by yourself or by a health care professional, and often require special handling. In addition, Express Scripts partners with Arriva Medical to fulfill prescription requests for certain drugs and supplies covered by Medicare Part B. For more information about Accredo or Arriva Medical, please call Express Scripts Member Services at **1-800-718-6590**.

Ordering Your Refills

You can order your refills by mail or by calling Express Scripts at **1-800-718-6590**, 24 hours a day, 7 days a week, except Thanksgiving and Christmas. For refills by mail, send the refill slip provided with your last mail-order prescription, along with your copayment, to Express Scripts, P.O. Box 747000, Cincinnati, Ohio 45274-7000. You may also order your refills online using Express Scripts' website at express-scripts.com. You can also check on the status of your refill online.

When Your Current Prescription Expires

Prescriptions expire one year from the date of issue, regardless of whether you have any refills left. You may mail your new prescription to Express Scripts, P.O. Box 747000, Cincinnati, Ohio 45274-7000. You may also have your physician fax your new prescription to Express Scripts or "e-prescribe". Ask your doctor to call 1-888-327-9791 for instructions.

For Kaiser HAP members

If you are in the Kaiser HAP, you must obtain covered drugs, supplies, and supplements from a network pharmacy or through Kaiser Permanente's mail-order service, unless the item is covered under emergency services, POST-STABILIZATION CARE, out-of-area URGENT CARE, or as otherwise specified. See "Emergency, Post-Stabilization, and Out-of-Area Urgent Care Received from Non-Network Providers – Kaiser HAP."

Refills

You may be able to order refills from a network pharmacy, Kaiser Permanente's mail-order service, or through Kaiser Permanente's website at kp.org/rxrefill. A network pharmacy can give you more information about obtaining refills, including the options available to you for obtaining refills. For example, a few network pharmacies don't dispense refills and not all drugs can be shipped through the mail-order service. Please check with your local network pharmacy if you have a question about whether or not your prescription can be mailed or

obtained from a network pharmacy. Items available through the mail-order service are subject to change at any time without notice.

Days' Supply Limit

The prescribing PHYSICIAN or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of days' supply coverage limits, network physicians determine the amount of an item that constitutes a MEDICALLY NECESSARY supply for you.

Upon payment of the cost sharing specified in this Prescription Drug Coverage section, you will receive the supply prescribed up to the days' supply limit also specified in this section. The days' supply limit is either a 30-day supply in a 30-day period or a 100-day supply in a 100-day period. If you wish to receive more than the covered days' supply limit, then you must pay charges for any prescribed quantities that exceed the days' supply limit.

Note: Episodic drugs prescribed for the treatment of sexual dysfunction disorders are covered up to a maximum of 8 doses in any 30-day period or up to 27 doses in any 100-day period.

The pharmacy may reduce the days' supply dispensed at the designated cost sharing to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your network pharmacy can tell you if a drug you take is one of these drugs).

Claims

Kaiser Permanente is the claims administrator for prescription drug coverage if you enrolled in the Kaiser HAP. For information on filing a claim, see "Filing a Claim."

What the HAP Covers

Covered expenses under the HAP consist of drugs and medicines approved by the Food and Drug Administration for general use by the public that require a written prescription by a PHYSICIAN and that are dispensed by a licensed pharmacist, physician, or HOSPITAL for take-home purposes. Eligible drugs and medicines include:

Is It Covered?

If you are not sure if a particular drug is covered, contact your HAP prescription drug administrator (Express Scripts at **1-800-718-6590** or Kaiser Permanente at **1-866-427-7701**). There are some prescriptions that require PRE-AUTHORIZATION.

- Drugs that require a prescription, except those specifically excluded under *What the HAP Doesn't Cover*;
- Compound drugs that contain at least one prescription drug (exclusions apply for certain compound ingredients; contact Express Scripts to verify coverage);
- Insulin, including hypodermic needles and syringes when insulin is also purchased;
- Over-the-counter diabetic supplies, including items used for daily blood and urine sample testing (except diabetic monitors);
- Retin-A for patients through age 30 (over age 30 when MEDICALLY NECESSARY);
- Vitamins that require a prescription;
- Attention Deficit Disorder drugs (e.g., Methylphenidate, Dextroamphetamine, Methamphetamine, Dextroamphetamine/Amphetamine);
- Smoking deterrents that require a prescription (e.g., Chantix, Nicoderm, and Nicotine anti-smoking patches); Anorexiants with pre-authorization;
- INFERTILITY, sexual dysfunction, and memory enhancement drugs (50% coverage, unless medically necessary); and
- Oral contraceptives.

Free Prescriptions

Some prescriptions will be free through your administrator. For Anthem HAP members, free prescription drugs are available only through the Express Scripts mail-order program. Preventive drugs on the ACA preventive services list are provided at $0 cost share. For Kaiser HAP members, free prescription drugs are available at Kaiser Permanente network pharmacies and through Kaiser's mail-order program. Listed drugs may change periodically; check with Express Scripts or Kaiser for updated information, or refer to the appropriate HAP Free Drug List on mypgebenefits.com.

Medically Necessary

The HAP only covers services and supplies that are medically necessary. For the purpose of prescription drugs, medically necessary services and supplies are those provided by a hospital, physician or other provider that: (i) have been established as safe and effective; (ii) are furnished in accordance with generally accepted professional standards to treat illness or injury, and are in accordance with the accepted standards of medical practice in the geographic area where the services are provided; (iii) are consistent with the symptoms and diagnosis or treatment of the illness, injury or condition; (iv) are furnished at the most appropriate level that can be provided safely and effectively to the patient; and (v) are not furnished primarily for the convenience of the patient, the attending physician or other provider. Medically necessary prescriptions will be paid at the standard level or rate of coverage.

How New Prescription Drugs Are Added

The HAP covers prescription drugs approved by the Food and Drug Administration (FDA), as long as they are used in the FDA-approved manner, used in accordance with manufacturers' usage guidelines, and approved by the Plan Administrator. Coverage for new prescription drugs will begin upon FDA approval.

What the HAP Does Not Cover

No benefit will be provided for any expense incurred for the following drugs, medicines, substances or supplies rendered, unless specifically listed as a benefit under What the HAP Covers. Ineligible drugs, medicines, substances and supplies include:

- For Kaiser members, any drug that is not obtained from a network pharmacy and is not on the formulary list (unless otherwise specified).
- Drugs, medicines, substances or supplies that are not MEDICALLY NECESSARY (see "Medically Necessary Services");
- Experimental and investigational drugs;
  - Experimental or investigational drugs are not covered under the HAP. These drugs are typically new products that are still being tested by the FDA and have not been approved for general distribution under the standard prescription process. Further, drugs that are limited by federal law to investigational use and that are labeled as such are not covered. A drug may also be considered experimental if prescribed for an indication or at a dosage that is not an accepted use based on published reports in standard drug publications such as the American HOSPITAL Formulary Service Drug Information and the United States Pharmacopeia Dispensing Information.
- Drugs or supplies that may be dispensed without a prescription;
- Medications not used in accordance with the FDA's approval specifications;
- Inpatient medications (i.e., drugs dispensed or used while you are a patient in a licensed hospital, rest home, sanitarium, extended care facility, SKILLED NURSING FACILITY, convalescent home, nursing home, or similar institution). Inpatient drugs are covered under the medical plan provisions of the HAP.
- Retin-A, unless medically necessary;
- Smoking deterrents other than those listed under What the HAP Covers;
- For Anthem members, allergy serums;

- Therapeutic devices or appliances;
- Drugs prescribed solely for cosmetic purposes (e.g., Renova) or to promote or stimulate hair growth (e.g., Rogaine);
- Immunization agents and vaccines;
- Biologicals, blood, or blood plasma;
- Charges for the administration or injection of a drug;
- Any prescription refill in excess of the number specified by the PHYSICIAN, or any refill after one year from the date of the physician's original order;
- Medications to which you are entitled under any Workers' Compensation or occupational disease law;
- Medication furnished by any other drug or medical service for which no charge is made to the participant; and
- Any drug for which benefits are paid under another Company-sponsored health plan or benefit program.

For further details, see "Reductions/Exclusions for Duplicate Coverage."

Coordination of Benefits – Anthem HAP

If you are covered by another plan that has prescription drug coverage that is primary to the Anthem HAP (see "If You Have Other Coverage"), you will need to ensure that the appropriate coordination of benefits forms have been submitted.

If you are an Anthem HAP member, you will need to fill out an Express Scripts Prescription Drug Reimbursement/Coordination of Benefits Form in order to receive any secondary benefit, if eligible, from Express Scripts. The form is available by calling Express Scripts Member Services at **1-800-718-6590**. It can also be downloaded from express-scripts.com, or at mypgebenefits.com.

You must submit a separate claim form for each pharmacy used and for each patient. You will need to attach documentation to the completed form. The documentation required depends on which plan is primary, as follows:

- If the primary plan is another health plan, you must attach the claim statement, or Explanation of Benefits, that you received from the primary plan to the completed Express Scripts form.
- If the primary plan is an HMO or another plan in which a copayment or coinsurance is paid at the pharmacy, you will need to attach receipts that clearly show the amounts you paid at the pharmacy.
- If the primary plan is another Express Scripts plan, you will need to attach either the prescription receipt or the statement of benefits you received from Express Scripts.

Complete instructions are included on the Express Scripts Prescription Drug Reimbursement/Coordination of Benefits Form.

Claims and Appeals

For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Care Plan for Active Employees, see "Claims and Appeals Process" and *Health Care Participation*.

For information on how to file a claim for prescription drug coverage, please see "Filing a Claim."

Glossary

The meanings of key terms used in the HAP section are included in this *Glossary*. The first time a defined term appears in a major subsection in *Health Care Participation*, the term is displayed in LARGE AND SMALL CAPS, to highlight that it is a defined term.

Accidental Injury

Physical harm or disability which is the result of a specific, unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Adverse Benefit Determination:

- A denial, reduction, or termination of a benefit by the Plan, a rescission of coverage by the Plan (as defined in 26 CFR 54.9815-2712T(a)(2), 29 CFR 2590.715-2712(a)(2), and 45 CFR 147.128(a)(2)), or a failure of the Plan to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of your, or your beneficiary's, eligibility to participate in the Plan;
- A denial, reduction, or termination of a benefit by the Plan, or a failure of the Plan to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review; and a failure of the Plan to cover an item or service for which benefits are otherwise provided because such item or service is determined to be experimental or investigational or not Medically Necessary or appropriate.
- The Plan's determination of whether a participant or beneficiary is entitled to a reasonable alternative standard for reward under a wellness program.
- The Plan's determination as to whether the Plan is complying with the non-quantitative treatment limitation parity provision of the Mental Health Parity and Addiction Equity Act.

Ambulatory Surgical Center

A freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care, or meet the health, safety, and other standards specified in regulations by the Department of Health and Human Services for participation in Medicare.

Kaiser members must use a Kaiser Permanente Network facility unless otherwise stated in this Handbook.

Annual Deductible

A fixed amount you pay out of pocket each year before the plan begins to pay benefits.

Clinically Stable

You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during, or as a result of, the discharge or transfer.

Effective Date

The date coverage begins under the HAP.

Eligible Expenses

Eligible expenses are: (1) expenses for covered health services that are covered by the Plan; (2) those that Anthem Blue Cross or Kaiser Permanente considers "medically necessary" for the diagnosis or treatment of an illness or injury; and (3) for Anthem HAP members, those that do not exceed the "maximum allowed amount" rate as determined by Anthem Blue Cross, as required under federal law, or, in the case of services rendered by network providers, the negotiated rate.

Additionally, for Kaiser members, Eligible Expenses are defined as:

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

Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Anthem Blue Cross Member Services or Kaiser Permanente Customer Service.

Experimental Procedures

Procedures that are mainly limited to laboratory and/or animal research.

Home Health Agencies

Home health care providers that are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Health Care Organizations.

Kaiser HAP members must use a Kaiser Permanente Network facility unless otherwise stated in this Handbook.

Hospice

An agency or organization primarily engaged in providing palliative care (pain control and symptom relief) to the terminally ill and providing supportive care to those persons and their families to help them cope with the patient's terminal illness. This care may be provided in the home or on an inpatient basis. A hospice must be: (1) certified by Medicare as a hospice; (2) recognized by Medicare as a hospice demonstration site; or (3) accredited as a hospice by the Joint Commission on Accreditation of Hospitals. A list of hospices meeting these criteria is available upon request by contacting Anthem Blue Cross Member Services or Kaiser Permanente Customer Service.

Kaiser HAP members must use a Kaiser Permanente Network facility unless otherwise stated in this Handbook.

Hospital

A facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of physicians. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations. Kaiser HAP members must use a Kaiser Permanente Network facility unless otherwise stated in this Handbook.

Infertility

A condition or status characterized by any of the following:

- A licensed physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.
- A person's inability to reproduce either as an individual or with their partner without medical intervention.
- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse.

Investigative

Procedures or medications that have progressed to limited use on humans but are not widely accepted as proven and effective within the organized medical community.

Medically Necessary

Medically necessary services are those procedures, supplies, equipment or services which your Claims Administrator determines to be:

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

Maximum Allowed Amount (Anthem)

Maximum allowed amount is the maximum amount of reimbursement Anthem will allow for covered medical services and supplies under this plan, or the amount of reimbursement required under federal law.

Negotiated Rate

For the Anthem HAP, a negotiated rate is the amount network providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Prudent Buyer Plan Participating Provider Agreements, Exclusive Provider Agreements and/or other Blue Card PPO Provider Agreements.

Network Provider

One of the following providers that has a network agreement in effect with the Claims Administrator at the time services are rendered:

- A hospital;
- A physician;
- An ambulatory surgical center;

- A home health agency;
- A facility that provides diagnostic imaging services;
- A durable medical equipment outlet;
- A skilled nursing facility;
- A clinical laboratory;
- A home infusion provider;
- An urgent care center;
- A retail health clinic;
- A hospice;
- A licensed ambulance company;
- A licensed qualified autism service provider.

Network providers agree to accept the negotiated rate as payment for covered services. A directory of network providers is available upon request by contacting Anthem Blue Cross Member Services or Kaiser Permanente Customer Service.

Non-Network Provider

Any provider that does not have a network agreement in place with the Claims Administrator, including:

- A hospital;
- A physician;
- An ambulatory surgical center;
- A home health agency;
- A facility that provides diagnostic imaging services;
- A durable medical equipment outlet;
- A skilled nursing facility;
- A clinical laboratory;
- A home infusion therapy provider;
- An urgent care center;
- A retail health clinic;
- A hospice;
- A licensed ambulance company; or
- A licensed qualified autism service provider,

For Anthem HAP members, unless otherwise required by federal law, only a portion of the amount which a non-network provider charges for a service may be treated as a covered expense; see "How Benefits Are Determined." For Kaiser HAP members, non-emergency services received from a non-network provider or facility are covered only for authorized referrals, emergencies and out-of-area urgent care. For details, see "Emergency, Post-Stabilization, and Out-of-Area Urgent Care Received from Non-Network Providers – Kaiser HAP."

Other Health Care Provider

One of the following providers:

- A certified registered nurse anesthetist;

- A blood bank.

The provider must be licensed to provide covered medical services according to state and local laws.

Physician

- A Doctor of Medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
- One of the following providers, but only when the provider is licensed to practice where the care is provided; the provider is rendering a service within the scope of that license; the provider is providing a service for which benefits are specified in this booklet; and benefits would be payable if the services were provided by a physician:
  - A dentist (D.D.S.)
  - An optometrist (O.D.)
  - A dispensing optician
  - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
  - A licensed clinical psychologist
  - A licensed educational psychologist for the provision of behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
  - A chiropractor (D.C.)
  - An acupuncturist (A.C.)
  - A licensed clinical social worker (L.C.S.W.)
  - A marriage and family therapist (M.F.T.)

Services obtained from the following providers are covered only by referral of a PHYSICIAN as defined in the first bullet above:

- A physical therapist (P.T. or R.P.T.)
- A speech pathologist
- An audiologist
- An occupational therapist (O.T.R.)
- A respiratory care practitioner (R.C.P.)
- A nurse midwife (for Anthem Blue Cross members only)
- A registered dietitian (R.D.) for the provision of covered medical nutrition therapy only

Post-Stabilization Care

Post-stabilization care is medically necessary services related to your emergency medical condition that you receive after your treating physician determines that your emergency medical condition is clinically stable.

Pre-Authorization

Approval obtained in advance required for some covered services. Pre-authorization is not a guarantee of payment under the Plan; all services must be medically necessary for reimbursement.

Region

A geographic region serviced by Kaiser Permanente. Each region contains service areas that cover a smaller geographic area.

Residential Treatment Center

An institution that provides continuous treatment for an illness related to mental health and alcohol/substance use disorders. The facility must be licensed as a residential treatment center according to state and local laws. The term residential treatment facility does not include a provider, or that part of a provider, used mainly for nursing care, rest care, convalescent care, care of the aged, custodial care, or educational care.

Service Area

For the Kaiser HAP, a service area is a smaller geographic area (county or portion of a county) of a Kaiser Permanente Region.

Skilled Nursing Facility

An institution that provides continuous skilled nursing services. The facility must be licensed according to state and local laws and must be recognized as a skilled nursing facility under Medicare.

Kaiser HAP members must use a Kaiser Permanente network facility unless otherwise stated in this Handbook.

Special Care Units

Special areas of a hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Stay

Inpatient confinement that begins when you are admitted to a facility and ends when you are discharged from that facility.

Urgent Care

The services received for a sudden, serious, or unexpected illness, injury or condition, other than one that is life threatening, which require immediate care for the relief of severe pain or diagnosis and treatment of the condition.

Claims and Appeals Process

For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Account Plan for Active Employees, see *Health Care Participation*.

Claims and Appeals — Medical Benefits

Your medical plan claims administrator depends on whether you're enrolled in the Anthem HAP or the Kaiser HAP.

- **If you're in the Anthem HAP**: Anthem Blue Cross, on behalf of Anthem Blue Cross Life & Health Insurance Company (referred to as "Anthem Blue Cross" or "Anthem" in this document), is your claims administrator. For Anthem members, the information contained in this "Claims and Appeals – Medical Benefits" section applies to claims for medical expenses only.
- **If you're in the Kaiser HAP:** Kaiser Permanente Insurance Company (referred to as "Kaiser," "Kaiser Permanente," or "Kaiser" in this document) is your claims administrator. For Kaiser members, the information contained in this "Claims and Appeals – Medical Benefits" section applies to claims for medical, mental health and substance use disorder, and prescription drug benefits administered by Kaiser Permanente.

Filing a Claim

Anthem HAP

- NETWORK PROVIDERS: When you receive care from a network provider, the network provider is responsible for submitting claims on your behalf, and Anthem Blue Cross pays the network provider directly for your covered health services. You are responsible for paying coinsurance and/or deductibles to the network provider once your claim is processed and you have received a bill from the provider. If the network provider bills you for a portion of any covered health services that the plan should have covered, contact Anthem Blue Cross at **1-800-964-0530**.
- NON-NETWORK PROVIDERS: When you receive care from a non-network provider, you are responsible for paying the provider up front for your covered health services and filing a claim with Anthem Blue Cross, even if your services were due to an emergency or if your network provider referred you to a non-network provider. Your claim for payment of benefits must include all information required to process the claim in a format acceptable to Anthem Blue Cross.

  You can obtain a claim form by calling Anthem Blue Cross at **1-800-964-0530**. You can also download a claim form at anthem.com/ca/pge.

  If a non-network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If your claim relates to an inpatient HOSPITAL STAY, the date of service is the date on which your inpatient stay ends.

  All claims for payment of benefits must be filed within **one year plus 90 days** of the date of service. If your claim isn't filed by this deadline, benefits for that health service will be denied. This time limit does not apply if you are legally incapacitated.

Kaiser HAP

- Network Providers: When you receive care from a network provider, the provider is responsible for submitting claims on your behalf, and Kaiser Permanente, on behalf of the Plan Sponsor, pays the provider directly for your covered health services. If a network provider bills you for a portion of any covered services (other than for cost sharing) that the Plan should have covered, please call Kaiser Permanente Customer Service.
- Non-Network Providers: When you receive eligible services from a non-network provider, and the provider has agreed to submit a claim on your behalf, eligible claims payment to the provider will require a form signed by

you, as a participant in the plan, that allows payment directly to the provider for administrative convenience. Even if the non-network provider agrees to submit a claim on your behalf, you are responsible for making sure that the claim is received within 365 days of the date of service and that all information necessary to process the claim is received.

If you have paid for eligible expenses, you must complete and mail a claim form (or write a letter) to the Claims Administrator at the address listed in Rules, Regulations & Administrative Information, within 365 days after you receive services.

To obtain a medical claim form, go to the Kaiser Permanente website, my.kp.org/ca/pge:

- log in with your username and password;
- go to "Coverage and Costs," then "Submit a Claim."

Contact Kaiser Permanente Customer Service (**1-800-663-1771 for the Northern California REGION and 1-800-533-1833 for the Southern California REGION**) if:

- a network provider bills you for a portion of any covered services (other than for cost sharing) that the plan should have covered; or
- you have any questions about submitting a claim for services received from a non-network provider.

Required Information for the Anthem and Kaiser HAP

When you request payment of benefits from Anthem Blue Cross or Kaiser Permanente, you must provide all of the following information as part of your claim:

- the member's name and address;
- the patient's name, age, and relationship to the member;
- the member identification number and group or health record number stated on your Anthem Blue Cross or Kaiser Permanente ID card;
- an itemized bill from your provider that includes the following:
  - patient diagnosis;
  - date(s) of service;
  - procedure code(s) and description of service(s) rendered;
  - charge for each service rendered; and
  - provider name, address, and Tax Identification Number (TIN)
- the date on which the injury or sickness began; and
- a statement indicating whether or not you are enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name(s) of the other carrier(s).

Send your claim to:

If you're in the Anthem HAP	If you're in the Kaiser HAP
Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	Kaiser Self-Funded Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547 Payor ID # 94320

Payment of Benefits for Non-Network Benefits – Anthem Blue Cross

Anthem Blue Cross will make a benefit determination on non-network services. Benefits will be paid directly to you, unless either of the following is true:

- The provider notifies Anthem Blue Cross that your signature is on file allowing payment directly to the provider for administrative convenience; or
- You make a written request for the NON-NETWORK PROVIDER to be paid directly at the time you submit your claim for administrative convenience.

Anthem Blue Cross will not reimburse third parties who have purchased or who have been assigned benefits from physicians or other providers.

Benefit Determinations (Before an Appeal Is Filed)

There are various types of benefit claims. Each benefit claim can be categorized as a post-service, pre-service, urgent, or concurrent claim. Depending on the type of the claim, Anthem Blue Cross or Kaiser must process your claim within different time frames. The processing time frames for each type of claim are explained in this section. You or your authorized representative may file a benefit claim.

Post-Service Claims

Post-service claims are those claims that are filed for payment of benefits after medical care has been received. The plan will pay you directly for covered post-service claims, unless:

- The provider notifies Anthem Blue Cross that your signature is on file allowing payment directly to the provider for administrative convenience; or
- You make a written request for the NON-NETWORK PROVIDER to be paid directly at the time you submit your claim for administrative convenience.

If your post-service claim is denied, Anthem Blue Cross or Kaiser will send you a written response in the form of an Explanation of Benefits (EOB) within 30 days of receipt of the claim, provided that all required information was included with the claim. The claims administrator will notify you within this 30-day period if additional information is needed to process your claim and may request a one-time extension of no longer than 15 days and pend your claim until all required information is received.

If notified that an extension is necessary due to incomplete claim information, you will have 45 days to provide the required information to Anthem Blue Cross or Kaiser. If all of the required information is received within the 45-day timeframe and the claim is then denied, Anthem Blue Cross or Kaiser will notify you of the denial within 15 days of receipt of the additional information. If you do not provide the needed information within the 45-day period, your claim will be denied.

Pre-Service Claims

Pre-service claims are those claims for services that require notification or approval prior to receiving the services. Requests for pre-service claims that are not urgent may be requested by the NETWORK PROVIDER by calling Anthem Blue Cross at **1-800-274-7767**, or Kaiser Permanente Customer Service at **1-800-663-1771** for the Northern California REGION or 1-800-533-1833 for the Southern California Region.

Or you can submit your claim in writing:

If you're in the Anthem HAP	If you're in the Kaiser HAP
Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	Kaiser Self-Funded Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547 Payor ID # 94320

If your claim is a pre-service claim and was submitted properly with all the required information, Anthem Blue Cross or Kaiser will send you and your network provider written notice of its claim decision within 15 days of receipt of the claim. If you file a pre-service claim improperly, Anthem Blue Cross or Kaiser will notify you and the network provider that the claim was improperly filed within five days of receiving the pre-service claim and will give you information on how to correct it. If additional information is needed to process the pre-service claim, Anthem Blue Cross or Kaiser will notify you within 15 days of receipt of the claim that additional information is needed and may request a one-time extension of no longer than 15 days and pend your claim until all required information is received.

If notification of an extension is necessary due to incomplete claim information, you will have 45 days to provide the required information to Anthem Blue Cross or Kaiser. If all of the required information is received within the 45-day timeframe, Anthem Blue Cross or Kaiser will notify you of its determination within 15 days of receipt of the additional information. If you don't provide the required information within the 45-day period, your claim will be denied.

Urgent Claims that Require Immediate Action

URGENT CARE claims are those claims that require notification or approval prior to receiving medical care and (1) could seriously jeopardize your life or health or your ability to regain maximum function, or (2) in the opinion of a PHYSICIAN with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

In these situations, where your claim is considered as urgent, you or your network provider may call Anthem Blue Cross at **1-800-274-7767**, or Kaiser Permanente Customer Service at **1-800-663-1771** for the Northern California Region or 1-800-533-1833 for the Southern California Region.

Or you can submit your urgent claim in writing:

If you're in the Anthem HAP	If you're in the Kaiser HAP
Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	Kaiser Self-Funded Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547 Payor ID # 94320

You and your network provider will receive notice of the claim determination in writing or by telephone as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless you or your network provider fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan.

In the case of a failure to provide sufficient information, Anthem Blue Cross or Kaiser will notify you or your network provider as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. You or your network provider will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Anthem Blue Cross or Kaiser will notify you or your network provider of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the plan's receipt of the specified information, or (2) the deadline to provide the additional information.

Notice of denial may be oral with written confirmation to follow within three days.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you or your network provider requests to extend the treatment as an urgent care claim, Anthem Blue Cross or Kaiser will make a determination on your request within 24 hours of receiving your request, provided your request is made at least 24 hours prior to the end of the approved treatment. Otherwise, your urgent care claim will be decided in accordance with the normal timeframe for urgent care claims.

If the request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Concurrent claims that are considered urgent may be submitted by calling Anthem Blue Cross at **1-800-274-7767**, or Kaiser Permanente Customer Services at **1-800-663-1771** for the Northern California Region or 1-800-533-1833 for the Southern California Region.

Or you can submit your urgent or non-urgent claim in writing:

If you're in the Anthem HAP	If you're in the Kaiser HAP
Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	Kaiser Self-Funded Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547 Payor ID # 94320

To Resolve a Problem

If You're in the Anthem HAP

Anthem Blue Cross has established a complaint resolution and appeal process to resolve members' problems or complaints. If you or a covered dependent has a question, problem, or complaint, you should call 1-800-964-0530 or write to the following address:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

If your question or concern is about a benefit determination, you should typically contact Member Services before filing a formal appeal. If the Member Services representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing or file an appeal. If you wish to file an appeal, you should contact Member Services again and state that you would like to file an appeal. You may also send your written appeal to Anthem Blue Cross at the following address:

Anthem Blue Cross
P.O. Box 4310
Woodland Hills, CA 91365-4310

If you are appealing a pre-service URGENT CARE claim denial, please refer to Urgent Claims that Require Immediate Action, earlier in this section, and contact **Member Services at 1-800-964-0530** immediately. The Member Services telephone number is also shown on your ID card. Member Services representatives are available to take your call during posted business hours, Monday through Friday.

If You're in the Kaiser HAP

You can lodge a service complaint. Here are some examples of reasons why you might lodge a complaint:

- You are not satisfied with the quality of care you received.
- You are dissatisfied with how long it took to get services, including getting an appointment, in the waiting room, or in the exam room.
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility.

If you have a question, problem or complaint, you can discuss your concerns with the Customer Service representatives at most facilities, or you can call Kaiser Permanente Customer Service at the number on your ID card. You may also appoint an authorized representative to help you file your complaint. A written authorization must be received from you before any information will be communicated to your representative.

Your problem or complaint must explain your concern, such as why you are dissatisfied with services received and this complaint must be submitted within 180 days of the date of the incident that caused your dissatisfaction. You can submit your complaint:

- at Kaiser Permanente facilities (please refer to your Kaiser Permanente welcome book for addresses);
- by calling the Kaiser Permanente Customer Service Call Center at the number on the back of your ID card; or
- by going to the Kaiser Permanente Customer Service website, my.kp.org/ca/pge, and submitting your complaint online.

You will receive a confirmation letter within five days after receipt of your complaint, and a written decision within 30 days after receipt of your complaint. Note: If your issue is resolved to your satisfaction by the end of the next business day after your complaint is received orally or through the website, and a Customer Service representative notifies you orally about the decision, you will not receive a confirmation letter or a written decision.

If Your Claim Is Denied

If your claim for benefits is denied, you will receive an adverse benefit determination. You are entitled to a full and fair review of the adverse benefit determination.

- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings);
- the specific reason(s) for the denial (including the denial code and its corresponding meaning, as well as a description of the plan's standard, if any, that was used in denying the claim);
- a reference to the specific plan provision(s) on which the claims administrator's determination is based;
- a description of any additional material or information needed to perfect your claim and an explanation of why such material or information is necessary;
- a description of the plan's review procedures, including information on how to initiate an appeal, and the time limits that apply to them, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination following completion of all required levels of review;
- a disclosure of any internal rule, guideline, protocol, or other similar criterion relied on in making the denial (or a statement that such information will be provided free of charge upon request);
- if the denial is based on a medical necessity or experimental treatment or similar limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances (or a statement that such information will be provided free of charge upon request);
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you; and
- for claims involving urgent care, the claims administrator's notice will also include a description of the applicable urgent care review process.

Your Right to Appeal

If you disagree with a claim determination after following the steps for filing a claim, you can file an appeal of an adverse benefit determination with Anthem Blue Cross or Kaiser. Your appeal must be filed within 180 days of receiving the adverse benefit determination. You or your authorized representative may file an appeal.

Appeals Process

You are entitled to a full and fair review of a denied claim. Anthem Blue Cross and Kaiser Permanente provide two levels of appeal for each claim: a first-level appeal and a second-level appeal. For certain claims, using both the first and second levels of appeals to your claims administrator is required before proceeding to External Review or court. For others, it is not.

A qualified individual who was not involved in an earlier denial of your claim will be appointed to decide the appeal. No deference will be afforded to any prior determination. If your claim involves a medical judgment question, Anthem Blue Cross or Kaiser will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved and who was not involved in any prior denial determination. Upon request, Anthem Blue Cross or Kaiser will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal, and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

The appeal will take into account all comments, documents, records, and other information you submitted relating to the claim, without regard to whether such information was submitted or considered in a prior benefit determination.

If new or additional evidence is considered, relied upon, or generated in connection with your claims, Anthem Blue Cross or Kaiser Permanente will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse claim determination on review based on a new or additional rationale, the claims administrator will provide you, free of charge, with the rationale and with an opportunity to respond to the new or additional rationale.

Further Review of Claims Involving Medical Judgments, Surprise Billing, or Rescissions of Coverage

If you are a HAP member whose claim involves medical judgment, a rescission of coverage, or an adverse determination for surprise bills (out-of-network emergency services, certain nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions) and you are not satisfied with the claim and appeal decisions of Anthem Blue Cross or Kaiser Permanente, you have the right to an External Review by an Independent Review Organization. For details regarding External Review, see "Your Right to External Review by an Independent Review Organization (IRO)."

First-Level Appeals

Urgent Care Appeals

Your appeal does not need to be submitted in writing. You or your PHYSICIAN should call Anthem Blue Cross at **1-800-274-7767**, or Kaiser Permanente Customer Service (**1-800-663-1771 for the Northern California REGION or 1-800-533-1833 for the Southern California Region**).

Second-level appeals of urgent claims are not required. However, if you wish to initiate a second appeal, you must follow the same steps as outlined below under "Non-Urgent Claim Appeals." Your second-level appeal must be submitted to Anthem Blue Cross or Kaiser Permanente within 60 days of your receipt of the first-level appeal decision. Again, a second-level appeal for urgent claims is not required for you to proceed with an External Review by an Independent Review Organization or file a lawsuit. For details regarding External Review, see "Your Right to External Review by an Independent Review Organization (IRO)."

Non-Urgent Care Appeals

You or your authorized representative must contact Anthem Blue Cross or Kaiser Permanente in writing to formally appeal the claim denial or adverse benefit determination. If the appeal relates to a claim for payment, your request should include:

- the patient's name and the identification number from your ID card;
- the date(s) of medical service(s);
- the provider's name;
- the reason you believe the claim should be paid; and
- any document or other written information to support your request for claim payment.

Send your appeal to:

If you're in the Anthem HAP	If you're in the Kaiser HAP
Anthem Blue Cross ATTN: Appeals P.O. Box 4310 Woodland Hills, CA 91365-4310	Kaiser Permanente Member Relations, Appeals P.O. Box 1809 Pleasanton, CA 94566 Fax: 1-888-987-2252 Phone: 1-800-788-0710

Your first level request to appeal the claim must be submitted to Anthem Blue Cross or Kaiser Permanente within 180 days of your receipt of the claim denial.

First-Level Appeals Determination

Responses to First-Level Appeals

You and your NETWORK PROVIDER will be provided written notification of Anthem Blue Cross' or Kaiser Permanente's decision on your first-level appeal as follows:

- **Urgent Care**: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt.
- **Pre-Service**: A reasonable period appropriate to the medical circumstances, but not later than 15 days after receipt.
- **Post-Service**: A reasonable period but not later than 30 days after receipt.

Please note that Anthem Blue Cross' or Kaiser Permanente's decision is based only on whether or not benefits are covered health services, as defined by the HAP. The determination as to whether the health service is necessary or appropriate is between you and your physician.

Second-Level Appeals

If you are dissatisfied with the Plan's first-level appeal decision, you may file a second-level appeal.

With respect to post-service claims, you must complete a first- and second-level appeal prior to submitting a request for an independent External Review or filing a lawsuit.

With respect to pre-service claims and URGENT CARE claims, you must complete a first-level appeal prior to submitting a request for an independent External Review or filing a lawsuit. You do not have to complete a second-level appeal prior to submitting a request for an independent External Review or filing a lawsuit.

If you would like to initiate a second-level appeal, please write to the address below. Second-level appeals must be submitted within 60 calendar days of the date on which your first-level appeal is denied. If you're in the Kaiser HAP, you may also fax your appeal.

If you're in the Anthem HAP	If you're in the Kaiser HAP
Anthem Blue Cross ATTN: Appeals P.O. Box 4310 Woodland Hills, CA 91365-4310	Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 1-888-987-2252 Phone: 1-800-788-0710

For details regarding External Review, including the deadline for requesting External Review, see "Your Right to External Review by an Independent Review Organization (IRO)."

Responses to Second-Level Appeals

You and your NETWORK PROVIDER will be provided written notification of Anthem Blue Cross' or Kaiser Permanente's decision on your second-level appeal as follows:

- **Pre-Service**: A reasonable period appropriate to the medical circumstances, but not later than 15 days after receipt.
- **Post-Service**: A reasonable period but not later than 30 days after receipt.

Please note that Anthem Blue Cross' or Kaiser Permanente's decision is based only on whether or not benefits are covered health services, as defined by the HAP. The determination as to whether the health service is necessary or appropriate is between you and your physician.

If Your Appeal Is Denied

If your first- or second-level appeal is denied, the denial letter will include:

- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings);
- the specific reason(s) for the denial (including the denial code and its corresponding meaning, as well as a description of the plan's standard, if any, that was used in denying the claim and a discussion of the decision);
- a reference to the specific plan provision(s) on which the claims administrator's determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- a description of any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures, and a statement of your right to bring an action under Section 502(a) of ERISA following completion of all required levels of review;
- a disclosure of any internal rule, guideline, protocol, or other similar criterion relied on in making the denial (or a statement that such information will be provided free of charge upon request);
- if the denial is based on a medical necessity or experimental treatment or similar limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances (or a statement that such information will be provided free of charge upon request); and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

Your Right to External Review by an Independent Review Organization (IRO)

If the outcome of all mandatory appeals is adverse to you, you can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of filing a civil action with respect to your claim under Section 502(a) of ERISA. To be eligible for independent external review, your claim must involve medical judgment, a rescission of coverage, or an adverse determination for surprise bills (out-of-network emergency services, certain nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions). Also, to be eligible for independent external review, generally, you must exhaust the mandatory internal plan claim review process described above (i.e., complete all mandatory levels of appeal), unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can both submit your appeal to the plan and request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the required internal appeal process.

Requesting External Review

You must file a request for external review within four months after the date you receive the final mandatory adverse benefit determination. If there is no corresponding date four months after the date of receipt of the determination, then the request must be filed by the first day of the fifth month following receipt of the determination. (If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline is the next business day.)

Submit your request to:

If you're in the Anthem HAP	If you're in the Kaiser HAP
Anthem Blue Cross ATTN: Appeals P.O. Box 4310 Woodland Hills, CA 91365-4310	Submit your request in writing with the following information: Name Phone Number Medical Record Number Statement indication you are requesting an "External Review" What you are appealing Any supporting documents (e.g., appeal denial letter) Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 1-888-987-2252 Phone: 1-800-788-0710

Expedited External Review

If you submit an expedited external review request, the Plan will immediately determine if you are eligible for an expedited external review. You may make a request for expedited external review at the time you receive (1) an adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal, or (2) a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

If you are eligible for expedited external review, the Plan will immediately determine if you are eligible for an external review and send you a letter notifying you whether your request for external review has been approved. The Plan will randomly assign the review request to an IRO with a physician that currently practices in the type of service you are seeking. The Plan will compile your appeal information on your behalf and send it to the IRO. The IRO will notify you in writing that the request for an external review was received. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will provide notice of its decision as expeditiously as your medical condition or circumstances require, but in no event more than within 72 hours after receiving the request for expedited external review. If the notice is not in writing, within 48 hours after the date of providing the notice, the IRO must provide written confirmation of the decision to you and the Plan. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a).

All Other Review Requests

If you submit an external review request, the Plan will review, within five business days following receipt of the request, your claim to determine if you are eligible for external review, and within one business day of its decision, send you a letter notifying you whether your request has been approved for external review.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO within five business days of assigning it to an IRO. The IRO will notify you in writing that it has received the request for an external review. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 45 calendar days and send you and the plan written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring a civil action under ERISA section 502(a).

Your Claim After External Review

You may have certain additional rights if you remain dissatisfied after you have exhausted all levels of review including external review. Since you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the **Employee Benefits Security Administration** (part of the U.S. Department of Labor) at **1-866-444-3272**. In addition, Consumer Assistance Programs under PHS Act Section 2793 may be available in your state for assistance. A list of the state Consumer Assistance Programs is available at https://www.cms.gov/cciio/resources/consumer-assistance-grants.

Reversal of the Claims Administrator's Decision

The IRO's decision is binding on the Plan but not on you. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the claims administrator will immediately provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

PG&E Voluntary Claims and Appeals Review Process

If you are not satisfied with the claims and appeals review process completed with Anthem or Kaiser, you may elect to use PG&E's Voluntary Claims and Appeals Review Process for all claims other than those relating to medical judgment, a rescission of coverage or an adverse determination for surprise bills (out-of-network emergency services, certain nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions), as described below, or elect to bring a civil action.

You have 90 days from the date of receipt of the final decision from Anthem or Kaiser to elect this claims and appeals review process. Initiation of the Voluntary Review Process does not restrict your ability to bring a civil action against the Plan. For claims relating to medical judgment, a rescission of coverage or an eligible adverse determination for surprise bills, you should use the External Review process described in the preceding section.

The first step of the Voluntary Claims and Appeals Review Process is to write to the PG&E Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include an AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PERSONAL HEALTH INFORMATION form. You can access a copy online at mypgebenefits.com (select Resources > Legal Notices), or by calling the PG&E Benefits Service Center at **1-866-271-8144**.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department - Appeals
300 Lakeside Drive
Oakland, CA 94612

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the Authorization form may delay your appeal). There may be special

circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

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

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

Benefits for an ongoing course of treatment will not be reduced or terminated while an appeal is pending. However, if the appeal is denied in whole or in part, you may be financially responsible for the cost of the denied portion.

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

- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under section 502(a) of ERISA.

Binding Arbitration for the Kaiser HAP

Scope of Arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- the claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to a participant or dependent party's relationship to Kaiser or Kaiser as a participant or dependent, a member, or a patient, including any claim for medical or HOSPITAL malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the delivery of services or items, irrespective of the legal theories upon which the claim is asserted;
- the claim is asserted by one or more Participant or Dependent Parties against one or more Kaiser Parties or by one or more Kaiser Parties against one or more Participant or Dependent Parties;
- the claim is *not* within the jurisdiction of the Small Claims Court; and
- the claim is *not* a benefit-related request that constitutes a "benefit claim" in Section 502(a)(1)(B) of ERISA.

As referred to in this "Binding Arbitration for the Kaiser HAP" section, a "Participant" or "Dependent Parties" include:

- a Participant or Dependent;

- a Participant's or Dependent's heir, relative, or personal representative; and
- any person claiming that a duty to him or her arises from a Participant's or Dependent's relationship to one or more Kaiser Parties

"Kaiser Parties" include:

- Kaiser Permanente Insurance Company;
- Kaiser Foundation Health Plan, Inc.;
- Kaiser Foundation Hospitals (KFH);
- KP Cal, LLC (KP Cal);
- The Permanente Medical Group, Inc. (TPMG);
- Southern California Permanente Medical Group (SCPMG);
- The Permanente Federation, LLC;
- The Permanente Company, LLC;
- any KFH, TPMG, or SCPMG PHYSICIAN;
- any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Participant or Dependent Parties; or
- any employee or agent of any of the foregoing

"Claimant" refers to a Participant or Dependent Party or a Kaiser Party who asserts a claim as described above. "Respondent" refers to a Participant or Dependent Party or a Kaiser Party against whom a claim is asserted.

Initiating Arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include all claims against Respondents that are based on the same incident, transaction, or related circumstances in the Demand for Arbitration.

Serving Demand for Arbitration

Kaiser Permanente Insurance Company (Kaiser), Kaiser Foundation Health Plan, Inc., KFH, KP Cal, TPMG, SCPMG, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of one of the following:

- If the claim relates to a Participant or Dependent who is assigned to the Kaiser Permanente Northern California Region:
- Kaiser Foundation Health Plan, Inc.
  Legal Department
  One Kaiser Plaza
  Oakland, CA 94612
- If the claim relates to a Participant or Dependent who is assigned to the Kaiser Permanente Southern California Region:

  Kaiser Foundation Health Plan, Inc.
  Legal Department
  393 E. Walnut St.
  Pasadena, CA 91188

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing Fee

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling Customer Service at the telephone number listed on your ID card.

Number of Arbitrators

The number of Arbitrators may affect the Claimant's responsibility for paying the neutral arbitrator's fees and expenses.

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two-party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of Arbitrators' Fees and Expenses

Kaiser Foundation Health Plan, Inc. will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure"). In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration for the Kaiser HAP" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

Rules of Procedure

Arbitrations shall be conducted according to the Rules of Procedure developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Customer Service.

General Provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party

fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration for the Kaiser HAP" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration for the Kaiser HAP" section.

In accord with the rule that applies under sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration for the Kaiser HAP" section shall not be denied, stayed, or otherwise impeded because a dispute between a Participant or Dependent Party and a Kaiser Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Arbitration Agreement for Participants and Dependents Assigned to the Kaiser Permanente Northern California Region or Southern California Region

I understand that if I am assigned to the Kaiser Permanente Northern California Region or Southern California Region, then except for Small Claims Court cases, cases subject to a Medicare appeals procedure, and certain benefit-related disputes, any dispute between myself, my heirs or relatives, or other associated parties on the one hand and Kaiser Permanente Parties on the other hand (Kaiser Permanente Insurance Company, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, The Permanente Medical Group, the Southern California Permanente Medical Group, or other associated parties), for alleged violation of any duty relating to or arising from a relationship to any of the Kaiser Permanente Parties as a participant in this medical plan, a member, or a patient, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the delivery of services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the summary plan description.

Claims and Appeal Process — Mental Health and Substance Use Disorder Benefits

If You're in the Anthem HAP

Carelon Behavioral Health is the claims administrator for mental health and substance use disorder benefits. As the claims administrator, Carelon Behavioral Health contracts with a network of providers and facilities and processes claims for services.

If You're in the Kaiser HAP

For the following benefits...	The claims administrator is...
Inpatient and Alternate Levels of Care for Mental Health	Kaiser Permanente
Outpatient Mental Health	
Detoxification, Inpatient and Residential Levels of Substance Use Disorder	Carelon Behavioral Health

For the following benefits...	The claims administrator is...
MEDICALLY NECESSARY Outpatient Substance Use Disorder	Kaiser Permanente
Structured Outpatient, Partial Hospitalization and Outpatient Substance Use Disorder	
Autism Applied Behavior Analysis	Carelon Behavioral Health or Kaiser Permanente, as applicable

Filing a Claim

If your mental health and substance use disorder benefits are administered by Kaiser, please see "Filing a Claim" for details on the claims filing process.

If your mental health and substance use disorder benefits are administered by Carelon Behavioral Health, the claims filing process is as follows:

- NETWORK PROVIDERS: When you receive services from a network provider or facility, the provider will send the claim directly to Carelon Behavioral Health for payment.
- NON-NETWORK PROVIDERS: When you receive services from a non-network provider or facility, and a provider has agreed to submit a claim on your behalf, eligible claims payment to the provider will require a valid assignment of benefits.

  If you have paid for services, your claim (or letter) requesting reimbursement, and all information necessary to process the claim, must be submitted to Carelon Behavioral Health.

All claims must be made within two years of the date on which services or supplies were received. Claim forms are available by calling Carelon Behavioral Health at **1-888-445-4436**.

Inquiries, Benefit Clarifications, and Claims

Many problems, complaints or potential claim issues can be resolved informally. In fact, most requests for services and inquiries can be handled over the telephone.

If your mental health and substance use disorder benefits are administered by Kaiser Permanente, please see "To Resolve a Problem" to receive assistance with questions, issues, or complaints.

If your mental health and substance use disorder benefits are administered by Carelon Behavioral Health, contact Carelon Behavioral Health at **1-888-445-4436** to:

- receive assistance with questions, issues, or complaints; or
- find a NETWORK PROVIDER

Benefit Determinations (Before an Appeal Is Filed)

There are various types of benefit claims. Each benefit claim can be categorized as a post-service, pre-service, urgent, or concurrent claim. Depending on the type of the claim, Carelon Behavioral Health must process your claim within different time frames.

The processing time frame for each type of claim is described in "Benefit Determinations (Before an Appeal Is Filed)" in "Claims and Appeals — Medical Benefits." If your claim is denied, the denial notice will include the information set forth in "If Your Claim Is Denied" in "Claims and Appeals — Medical Benefits."

Your Right to Appeal

If your mental health and substance use disorder benefits are administered by Kaiser Permanente, please see "To Resolve a Problem" for details on appeals.

If your mental health and substance use disorder benefits are administered by Carelon Behavioral Health, the claims appeals process is as follows:

If you disagree with a claim determination after following the steps for filing a claim, you can file an appeal of an adverse benefit determination with Carelon Behavioral Health. Your appeal must be filed within 180 days of receiving the adverse benefit determination.

Appeals Process

Non-Urgent

If you are not satisfied with Carelon Behavioral Health's determination resolution or you believe you have received some other type of adverse benefit determination that is preventing you from receiving the services you requested in the process of trying to obtain a benefits certification, you can appeal the benefit denial/determination within 180 days of receipt of the denial or adverse determination. Your appeal may be made in writing or by calling Carelon Behavioral Health at **1-888-445-4436**. If you submit your appeal in writing, you must include the following information: your name, member ID, phone number, the service for which benefit coverage has been denied, and any additional information that may be relevant to your appeal. The appeal should be sent to:

Carelon Behavioral Health
Attention: Appeals
P.O. Box 6065
Cypress, CA 90630-0065

Carelon Behavioral Health will mail you a decision notice within 15 calendar days of receipt of your appeal. The notice will include the specific reason(s) for the decision and the Plan provision(s) on which the decision was based. You have the right to receive, upon request only and at no charge, the information used by Carelon Behavioral Health to review your appeal.

If you are not satisfied with Carelon Behavioral Health's decision, you have 90 days from the date of your receipt of the decision notice to request a second level of appeal. To initiate a second level of appeal, you can submit the appeal in writing by sending it to the Carelon Behavioral Health address above or you can call Carelon Behavioral Health at **1-888-445-4436**. A professional committee composed of two or more members who were not involved in the initial decision will conduct the review. The decision regarding your request will be sent to you within 15 calendar days of its receipt by Carelon Behavioral Health. If at this point your appeal is denied, you can bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

Urgent

If your appeal for coverage involves URGENT CARE, you can request an expedited review by telephoning or writing to Carelon Behavioral Health. You will be notified of the benefit determination within 72 hours of Carelon Behavioral Health's receipt of the appeal (within one day for concurrent care). A Medical Department representative will contact your provider to schedule a time for a telephone review of your case. Your provider will be advised of the determination at the end of the telephone review. A written notification of the decision will be sent to you and your provider within three calendar days of the verbal notification. If you or your provider has additional information to be included in the appeal, you will need to provide the additional information within three days of the appeal request.

An urgent appeal is any claim for treatment with respect to which the application of the time periods for a non-urgent care determination could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function or, in the opinion of a PHYSICIAN with knowledge of the claimant's medical condition, could subject the claimant to severe pain that cannot be adequately managed.

If you receive an adverse benefit determination of your appeal, you have the right to further appeal the decision. You have 90 days to request a second level of appeal. A professional committee composed of two or more

members, or a board-certified MD Peer Advisor, who was not involved in the initial decision, will conduct the review. A benefit determination will be sent to you and your provider within 15 calendar days of your request. You may submit the appeal in writing or by calling Carelon Behavioral Health at **1-888-445-4436**.

Written appeals should be sent to the following address:

Carelon Behavioral Health
Attention: Appeals
P.O. Box 6065
Cypress, CA 90630-0065

Expedited Review for Urgent Appeals

You have the right to an expedited review for urgent appeals involving an imminent and serious threat to the health of the Member, including but not limited to severe pain, potential loss of life, limb, or major bodily functions. The request may be initiated by you, your authorized representative, or by your provider. Call Carelon Behavioral Health at **1-888-445-4436** and tell the representative that you are requesting an expedited review of an urgent appeal. Carelon Behavioral Health will notify the provider of the decision in no more than 72 hours and send the Member a written statement on the disposition or pending status of the appeal within the same 72 hours from receipt of the appeal.

Carelon Behavioral Health Carelon Behavioral Health

Post-Service Appeals

If you believe that your claims were processed or denied incorrectly, you can try to resolve the issue informally as described under "Inquiries, Benefit Clarifications, and Claims." If this approach is unsatisfactory, you may appeal the initial claim determination. To initiate an appeal, you must write or telephone Carelon Behavioral Health at **1-888-445-4436** within 180 days of receipt of the claim processing determination. Your appeal must include the following information: your name, member ID, phone number, a copy of the denied or incorrectly processed claim and any additional information that may be relevant to your appeal. Written appeals should be sent to:

Carelon Behavioral Health
Attention: Clinical Appeals
P.O. Box 6065
Cypress, CA 90630-0065

OR

Carelon Behavioral Health
Attention: Admin Appeals
P.O. Box 1851
Hicksville, NY 11802-1851

A decision notice will be mailed to you within 30 days of receipt of your appeal by Carelon Behavioral Health. The notice will include the specific reason(s) for the decision and a reference to the Plan provision(s) on which the decision was based. You also have the right to receive, only upon request and at no charge, the information that Carelon Behavioral Health used to review your appeal. If the information you submit with your appeal is incomplete, you will be notified by letter of the additional information needed. If you do not send the information within 45 days of the date on which you received the letter, an administrative denial may be issued.

If at this point your appeal is denied, you can bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

Submitting an Appeal

You must submit your appeal within 180 calendar days following receipt of an adverse determination notice, or following any incident or action that is the subject of your dissatisfaction. Appeals may be filed telephonically, in person, in writing, by facsimile, by email or online through the Carelon Behavioral Health website, carelonbehavioralhealth.com. Carelon Behavioral Health will mail an appeal form to you for this purpose, and a copy of Carelon Behavioral Health's Appeals Procedure, upon request. If you wish, Carelon Behavioral Health's Member Services staff will assist in completing the Appeal form. Completed Appeal forms must be mailed to

Carelon Behavioral Health at P.O. Box 6065, Cypress, California, 90630-0065. Carelon Behavioral Health will acknowledge receipt of an appeal within five calendar days of receipt of the appeal.

If Your Appeal is Denied

If your appeal is denied, the denial notice will include the information set forth in "If Your Appeal is Denied" in "Claims and Appeals — Medical Benefits" above.

Your Right to External Review by an Independent Review Organization (IRO)

For mental health and substance use disorder benefits administered by Kaiser Permanente, please see "Your Right to External Review by an Independent Review Organization (IRO)."

For mental health and substance use disorder benefits administered by Carelon Behavioral Health, your right to an external review is as follows:

If the outcome of all mandatory appeals is adverse to you, you can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of filing a civil action with respect to your claim under Section 502(a) of ERISA. To be eligible for independent external review, your claim must involve medical judgment, a rescission of coverage, or an adverse determination for surprise bills (out-of-network emergency services, certain nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions). Also, to be eligible for independent external review, generally, you must exhaust the mandatory internal plan claim review process described above (i.e., complete all mandatory levels of appeal), unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can both submit your appeal to the plan and request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the required internal appeal process.

Requesting External Review

You must file a request for external review within four months after the date you receive the final mandatory adverse benefit determination. If there is no corresponding date four months after the date of receipt of the determination, then the request must be filed by the first day of the fifth month following receipt of the determination. (If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline is the next business day.)

Submit your request to:

Carelon Behavioral Health
Attn: External Review
P.O. Box 1851
Hicksville, NY 11802-1851
Fax for expedited requests: 1-877-826-8584

Expedited External Review

If you submit an expedited external review request, the Plan will immediately determine if you are eligible for an expedited external review. You may make a request for expedited external review at the time you receive (1) an adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal, or (2) a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

If you are eligible for expedited external review, the Plan will immediately determine if you are eligible for an external review and send you a letter notifying you whether your request for external review has been approved. The Plan will randomly assign the review request to an IRO with a physician that currently practices in the type of service you are seeking. The Plan will compile your appeal information on your behalf and send it to the IRO. The IRO will notify you in writing that the request for an external review was received. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will provide notice of its decision as expeditiously as your medical condition or circumstances require, but in no event more than within 72 hours after receiving the request for expedited external review. If the notice is not in writing, within 48 hours after the date of providing the notice, the IRO must provide written confirmation of the decision to you and the Plan. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a).

All Other Review Requests

If you submit an external review request, the Plan will review, within five business days following receipt of the request, your claim to determine if you are eligible for external review, and within one business day of its decision, send you a letter notifying you whether your request has been approved for external review.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO within five business days of assigning it to an IRO. The IRO will notify you in writing that it has received the request for an external review. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 45 calendar days and send you and the plan written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring a civil action under ERISA section 502(a).

Your Claim After External Review

You may have certain additional rights if you remain dissatisfied after you have exhausted all levels of review including external review. Since you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the **Employee Benefits Security Administration** (part of the U.S. Department of Labor) at **1-866-444-3272**. In addition, Consumer Assistance Programs under PHS Act Section 2793 may be available in your state for assistance. A list of the state Consumer Assistance Programs is available at https://www.cms.gov/cciio/resources/consumer-assistance-grants.

Reversal of the Claims Administrator's Decision

The IRO's decision is binding on the Plan but not on you. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the claims administrator will immediately provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

PG&E Voluntary Claims and Appeals Review Process

If you are not satisfied with the claims and appeals review process completed with Carelon Behavioral Health or Kaiser, you may elect to use PG&E's Voluntary Claims and Appeals Review Process for all claims other than those relating to medical judgment, a rescission of coverage or an adverse determination for surprise bills (out-of-network emergency services, certain nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions), as described below, or elect to bring a civil action.

You have 90 days from the date of receipt of the final decision from Carelon Behavioral Health or Kaiser to elect this claims and appeals review process. Initiation of the Voluntary Review Process does not restrict your ability to bring a civil action against the Plan. For claims relating to medical judgment, a rescission of coverage or an eligible adverse determination for surprise bills, you should use the External Review process described in the preceding section.

The first step of the Voluntary Claims and Appeals Review Process is to write to the PG&E Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite

processing, you should also include an AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PERSONAL HEALTH INFORMATION form. You can access a copy online at mypgebenefits.com (select Resources > Legal Notices), or by calling the PG&E Benefits Service Center at **1-866-271-8144**.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department - Appeals
300 Lakeside Drive
Oakland, CA 94612

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the Authorization form may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

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

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

Benefits for an ongoing course of treatment will not be reduced or terminated while an appeal is pending. However, if the appeal is denied in whole or in part, you may be financially responsible for the cost of the denied portion.

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

- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under section 502(a) of ERISA.

Claims and Appeals — Prescription Drug Benefits

If you're in the Anthem HAP	If you're in the Kaiser HAP
Express Scripts is the claims administrator for prescription drug benefits.	Kaiser Permanente is the claims administrator for prescription drug benefits.

Filing a Claim

For prescription drug benefits administered by Kaiser Permanente, please see "Filing a Claim" for details on the claims filing process.

For prescription drug benefits administered by Express Scripts, the claims filing process is as follows:

- Participating Retail Pharmacies: When you receive services from a participating retail pharmacy, simply present your Express Scripts identification card and pay the appropriate coinsurance. There are no claim forms to file.
- Non-Participating Pharmacies: You will be responsible for paying the full cost of the prescription to the pharmacist, and then filing a claim for reimbursement. Claim forms are available by calling Express Scripts at **1-800-718-6590** or at Express Scripts' website, express-scripts.com (scroll to the bottom of the Home page and click on Health & Benefits Information > Print & Request Forms & Cards). If you are a first-time visitor to the website, you'll need to register as a user. Please remember to have your member ID number and a recent prescription number handy when you register. Claim forms can also be obtained at the Anthem Member pages on mypgebenefits.com under Physical Health.

All claims for prescription drugs, except controlled substances, must be made within 12 months of the date on which the prescription was written by the PHYSICIAN. If you do not file a claim within this timeframe, your claim will be denied. All claims for controlled substances must be made within six months of the date on which the prescription was written by the physician.

Other Circumstances When Claim Forms Are Required

There are other circumstances that require you to pay the full cost of your prescription and file a claim form for reimbursement with Express Scripts. These include:

- Purchasing drugs at a participating pharmacy without presenting your Express Scripts identification card (reimbursement will be limited to the cost for the drug negotiated by Express Scripts and the pharmacy; any additional amounts charged to you by the pharmacy will be your responsibility); or
- Having other prescription drug coverage pay benefits first, with Express Scripts serving as secondary payor on any claim remainder. This is called a Coordination of Benefits or "COB" claim; see "If You Have Other Coverage."

The form for obtaining reimbursement from Express Scripts, the "Prescription Drug Reimbursement / Coordination of Benefits Claim Form," is available by calling Express Scripts Member Services at 1-800-718-6590. It can also be downloaded at express-scripts.com or under the Anthem Member pages at mypgebenefits.com under Physical Health.

Benefit Determinations (Before an Appeal Is Filed)

There are various types of benefit claims. Each benefit claim can be categorized as a post-service, pre-service, urgent, or concurrent claim. Depending on the type of the claim, Express Scripts must process your claim within different time frames.

The processing time frame for each type of claim is described in "Benefit Determinations (Before an Appeal Is Filed)" in "Claims and Appeals — Medical Benefits." If your claim is denied, the denial notice will include the information set forth in "If Your Claim Is Denied" in "Claims and Appeals — Medical Benefits."

To Resolve a Problem

If you have an issue or complaint regarding your prescription drug benefits, you should first address your concerns with the claims administrator (Express Scripts or Kaiser Permanente, as applicable).

For prescription drug benefits administered by Kaiser Permanente, please see "To Resolve a Problem" for assistance with questions, issues, or complaints.

For prescription drug benefits administered by Express Scripts, refer to the information in this section.

Contact Express Scripts within 60 days after the issue or complaint arises. Many problems, complaints, and potential claim issues can be resolved informally. You can address these informal complaints by phoning Express Scripts at **1-800-718-6590**. Express Scripts may ask you to provide additional information or ask your PHYSICIAN to do so or may try to clarify any information already provided. Express Scripts will research your issue and respond

to you on its findings either in writing or by telephone within 15 days for prescriptions that have not been filled, and within 30 days for prescriptions that have already been filled and paid.

Your Right to Appeal

For prescription drug benefits administered by Kaiser Permanente, please see "Claims and Appeals Process" for details on appeals.

For prescription drug benefits administered by Express Scripts, refer to the information in this section.

If you disagree with a claim determination after following the steps for filing a claim, you can file an appeal of an adverse benefit determination with Express Scripts. Your appeal must be filed within 180 days of receiving the adverse benefit determination.

Appeals Process

Express Scripts provides two levels of appeal for each claim: a first-level appeal and a second-level appeal.

First-Level Appeals

Non-Urgent Appeal

If you are not satisfied with the decision regarding your benefit coverage or you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered denied because missing information was not timely submitted), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of the notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your PHYSICIAN). To initiate an appeal for coverage, provide in writing:

- your name;
- member ID;
- phone number;
- the prescription drug for which benefit coverage has been denied;
- the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes); and
- any additional information that may be relevant to your appeal.

Below is where this information should be mailed according to the type of appeal requested:

- For a clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. This would include, for example, appealing access to a new cancer drug.

  Clinical appeal requests:

  Express Scripts Attn: Clinical Appeals Department
  P.O. Box 66588
  St Louis, MO 63166-6588

For an administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design. This would include, for example, filing an appeal because you would like a lower copay/coinsurance for a certain drug.

Administrative appeal requests:

Express Scripts Attn: Administrative Appeals Department
P.O. Box 66587
St Louis, MO 63166-6587

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request for pre-service claims or within 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any, considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes, contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes, and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal.

Urgent Claim Appeals that Require Immediate Action

In the case of a claim for coverage involving URGENT CARE, you will be notified of the benefit determination within 24 hours of receipt of the claim. If you receive an adverse determination on your claim, you will be provided with a written statement that explains the denial and includes instructions on how to appeal that decision.

An urgent care claim is defined as a request for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your claim is considered denied and you have the right to appeal as described below.

Second-Level Appeal

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of receipt of the notice of the decision, a second-level appeal. A second-level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second-level appeal, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and
- any additional information that may be relevant to your appeal.

Below is where this information should be mailed according to the type of appeal requested:

For a clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.

Clinical appeal requests:

Express Scripts Attn: Clinical Appeals Department
P.O. Box 66588
St Louis, MO 63166-6588

For an administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design. For example, if a medication is prescribed for something other than its normal intended use.

Administrative appeal requests:

Express Scripts Attn: Administrative Appeals Department
P.O. Box 66587
St Louis, MO 63166-6587

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or within 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any, considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes, contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes, and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second-level appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your second-level appeal, such information will be provided to you together with an opportunity to respond prior to issuance of any final adverse determination of this appeal. The decision made on your second-level appeal is final.

If your second-level appeal is denied and you are not satisfied with the decision of the second-level appeal (i.e., your "final adverse benefit determination"), you also have the right to bring a civil action under ERISA section 502(a) and/or to submit your claim for review by an external review organization. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. External reviews are not available for decisions relating to eligibility.

If Your Appeal is Denied

If your appeal is denied, the denial notice will include the information set forth in "If Your Appeal is Denied" in "Claims and Appeals — Medical Benefits" above.

Your Right to External Review by an Independent Review Organization (IRO)

For prescription drug benefits administered by Kaiser Permanente, please see "Claims and Appeals Process" for details on your right to external review.

If the outcome of all mandatory appeals is adverse to you, you can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of filing a civil action with respect to your claim under Section 502(a) of ERISA. To be eligible for independent external review, your claim must involve medical judgment, a rescission of coverage, or an adverse determination for surprise bills (out-of-network emergency services, certain nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions). Also, to be eligible for independent external review, generally, you must exhaust the mandatory internal plan claim review process described above (i.e., complete all mandatory levels of appeal), unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can both submit your appeal to the plan and request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the required internal appeal process.

Requesting External Review

You must file a request for external review within four months after the date you receive the final mandatory adverse benefit determination. If there is no corresponding date four months after the date of receipt of the determination, then the request must be filed by the first day of the fifth month following receipt of the determination. (If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline is the next business day.)

Submit your request to:

Express Scripts
Attention: External Review Requests
P.O. Box 631850
Irving, TX 75063-0030

Phone: 1-800-753-2851
Fax: 1-888-235-8551

Expedited External Review

If you submit an expedited external review request, the Plan will immediately determine if you are eligible for an expedited external review. You may make a request for expedited external review at the time you receive (1) an adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal, or (2) a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

If you are eligible for expedited external review, the Plan will immediately determine if you are eligible for an external review and send you a letter notifying you whether your request for external review has been approved. The Plan will randomly assign the review request to an IRO with a physician that currently practices in the type of service you are seeking. The Plan will compile your appeal information on your behalf and send it to the IRO. The IRO will notify you in writing that the request for an external review was received. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will provide notice of its decision as expeditiously as your medical condition or circumstances require, but in no event more than within 72 hours after receiving the request for expedited external review. If the notice is not in writing, within 48 hours after the date of providing the notice, the IRO must provide written confirmation of the decision to you and the Plan. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a).

All Other Review Requests

If you submit an external review request, the Plan will review, within five business days following receipt of the request, your claim to determine if you are eligible for external review, and within one business day of its decision, send you a letter notifying you whether your request has been approved for external review.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO within five business days of assigning it to an IRO. The IRO will notify you in writing that it has received the request for an external review. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 45 calendar days and send you and the plan written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring a civil action under ERISA section 502(a).

Your Claim After External Review

You may have certain additional rights if you remain dissatisfied after you have exhausted all levels of review including external review. Since you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the **Employee Benefits Security Administration** (part of the U.S. Department of Labor) at **1-866-444-3272**. In addition, Consumer Assistance Programs under PHS Act Section 2793 may be available in your state for assistance. A list of the state Consumer Assistance Programs is available at https://www.cms.gov/cciio/resources/consumer-assistance-grants.

Reversal of the Claims Administrator's Decision

The IRO's decision is binding on the Plan but not on you. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the claims

administrator will immediately provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

PG&E Voluntary Claims and Appeals Review Process

If you are not satisfied with the claims and appeals review process completed with Express Scripts or Kaiser Permanente, you may elect to use PG&E's Voluntary Claims and Appeals Review Process for all claims other than those relating to medical judgment, a rescission of coverage or an adverse determination for surprise bills (out-of-network emergency services, certain nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions), as described below, or elect to bring a civil action.

You have 90 days from the date of receipt of the final decision from Express Scripts or Kaiser Permanente to elect this claims and appeals review process. Initiation of the Voluntary Review Process does not restrict your ability to bring a civil action against the Plan. For claims relating to medical judgment, a rescission of coverage or an eligible adverse determination for surprise bills, you should use the External Review process described in the preceding section.

The first step of the Voluntary Claims and Appeals Review Process is to write to the PG&E Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include an AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PERSONAL HEALTH INFORMATION form. You can access a copy online at mypgebenefits.com (select Resources > Legal Notices), or by calling the PG&E Benefits Service Center at **1-866-271-8144**.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department - Appeals
300 Lakeside Drive
Oakland, CA 94612

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the Authorization form may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

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

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

Benefits for an ongoing course of treatment will not be reduced or terminated while an appeal is pending. However, if the appeal is denied in whole or in part, you may be financially responsible for the cost of the denied portion.

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

- the specific reason(s) for the denial;

- a reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under section 502(a) of ERISA.

Wellness Program and Similar Benefits

The Pacific Gas and Electric Company, and PG&E Corporation and its covered affiliates (referred to collectively as the "Company" in this section) partner with Quest Diagnostics and Personify Health to offer a Wellness Program. The program helps you and your family to improve your health through education, tools and resources designed to facilitate health and overall well-being.

Eligibility

All union-represented employees who are eligible for PG&E's active medical plan are eligible to participate in the Wellness Program. Additionally, spouses or domestic partners are able to be invited by eligible employees to participate in certain Wellness activities. However, only employees enrolled in PG&E's active medical plan will earn incentive credits or savings contributions for health screenings and tobacco-free testing or tobacco cessation completion, and only employees are eligible to participate in the health screening and tobacco-free testing.

Health Screenings

The Health Account Plan covers annual health screenings for employees to identify risk factors that can lead to chronic disease and set health goals that can help delay or prevent these conditions.

For more information, please see "Health Screenings."

PG&E's voluntary health screening program complies with all federal laws and regulations, including your right to have the privacy and security of your Personal Health Information (PHI) maintained in a confidential and secure manner. Notices about PG&E's Wellness Program and its protection of your medical information can be accessed online at mypgebenefits.com > Legal Resources.

Health & Wellness Portal

A variety of tools and resources are available at **join.personifyhealth.com/pgewellness,** including: a Health Check survey, healthy habit tools and trackers, team challenges, nutrition and sleep guides, mindfulness and yoga training and much more. Through the Personify Health Health & Wellness portal you'll also have access to free telephonic and digital health coaching and tobacco cessation programs.

Here are some of the resources available on the portal:

- Health Check survey to help you identify any health risks, with a personalized wellness score and recommended actions you can take to start making changes to improve your health.
- Receive a personalized nutrition plan, along with guidance to adopt healthy eating habits with tracking tools, recipes, meal planning, and nutrition resources, tips and reminders.
- Leverage the Sleep Guide to obtain your sleep goals with a personalized sleep plan **and** adopt healthy sleep habits with sleep tracking tools, resources, tips and reminders.
- Daily food logs through MyFitnessPal help you track your meals and analyze your daily nutrition;
- Sync a device or manually track your activities with the Workout Log, Active Minutes Log and Step Tracker to help you plan and monitor progress toward your fitness goals.
- Training videos focused on mindfulness, yoga, and emotional intelligence.
- Digital health coaching to improve your habits through small steps and motivating content.
- Invite up to ten friends and family members to participate in personal Challenges.
- Join and create groups based on your personal interests to add social support.

To access the Health & Wellness portal, go to: **https://join.personifyhealth.com/pgewellness** or download the Personify Health mobile app from the Apple App Store or on Google Play.

Health Coaching

In Personify Health's health coaching program, you can team up with a dedicated health coach to get personalized support for your health and wellness goals based on your unique needs and interests. Your health coach can support you across a wide range of health topics, including but not limited to:

- Weight management
- Stress management
- Physical activity
- Nutrition
- Tobacco use
- Heart health
- Sleep health
- Diabetes health

You can enroll and schedule your health coaching appointment through the Health and Wellness portal. To enroll, go to join.personifyhealth.com/pgewellness or download the Personify Health app.

Once enrolled you may either schedule your appointment online or through the app, or you may call 1-888-573-3113. You also have access to the Journeys® Digital Coaching tool on the portal.

In addition, Kaiser HAP-enrolled members interested in telephonic wellness coaching to manage weight, quit tobacco, reduce stress, increase activity, or eat healthier can visit kp.org/wellness coaching for more information. Anthem HAP-enrolled members can see their doctor to learn more about Anthem-specific programs, or visit anthem.com/ca/pge to learn more about the health resources available.

Tobacco Cessation Program

To help you towards a tobacco-free life, PG&E offers a free telephonic tobacco cessation program to employees providing one-on-one support with a certified tobacco cessation specialist.

Personify Health administers PG&E's tobacco cessation program, which includes the following components:

- Setting a quit date
- Quit date preparation
- Identification of tobacco use triggers and coping strategies
- Individualized cessation plan
- Relapse prevention
- Risk-factor education
- Instruction on appropriate use of over-the-counter pharmacotherapy including nicotine replacement therapy (NRT) and availability of prescription medications to improve quit rates
- You may obtain up to two months of free nicotine replacement therapy (NRT) through the Personify Health tobacco cessation program.

You can enroll and schedule your telephonic tobacco cessation appointment through the Health and Wellness portal. To enroll, go to join.personifyhealth.com/pgewellness or download the Personify Health app.

Once enrolled you may either schedule your appointment online or through the app, or you may call 1-888-573-3113.

For information on how to earn additional Health Account credits by completing the Personify Health telephonic tobacco cessation program, please see "Tobacco-Free Program."

In addition, PG&E Kaiser HAP members can see their doctor or contact Kaiser for information on the Kaiser tobacco cessation program. Anthem HAP-enrolled members can see their doctor for information on how to quit smoking, and to learn about available resources.

Gym and Fitness Discount Program

PG&E employees and their family members who are enrolled in PG&E's active medical plans are eligible for discounts at various fitness clubs, as well as discounts on select home fitness equipment, and other health services.

To find a participating gym near you, or more information about fitness and health services discounts visit mypgebenefits.com > Physical Health > Wellness Programs.

KnovaSolutions

This benefit is available to eligible individuals through December 31, 2026.

KnovaSolutions supports employees and their families who may be dealing with complex health needs. This can include things like managing multiple health conditions, taking several prescription medications, having abnormal biometric results, using workers' compensation or disability benefits, or navigating a single high-cost condition or specialty medication.

KnovaSolutions is offered at no cost to you. While many people are invited to participate based on their health information, you can also call us directly to find out whether you or your family members are eligible. Services are available by phone, email, video, and mobile app. If you meet the criteria, our team will reach out, or you're welcome to reach out to us anytime.

All active employees, as well as eligible family members enrolled in the Anthem Health Account Plan, Kaiser Health Account Plan, and employees on Long-Term Disability (and their covered family members), may qualify for services.

Your KnovaSolutions support is provided by an independent team of experts, including nurse clinicians, pharmacists, dietitians, diabetes educators, and medical research librarians. Our team is here to help you understand your health care options, navigate complex decisions, and feel supported every step of the way.

To contact KnovaSolutions, call 1-800-355-0885 or email contactknovasolutions@workpartners.com.

Hinge Health

This benefit is available to eligible individuals through December 31, 2026.

Hinge Health covers the entire continuum of musculoskeletal care. Hinge Health combines advanced technology with the expertise of a clinical care team, to align members with care that is personalized to meet their unique goals and improve their overall quality of life.

Hinge Health offers members care for:

- Prevention – Prevent future injury and improve health and wellness
- Acute — Recover from a specific injury
- Chronic — Treat the physical and behavioral aspects of chronic MSK pain
- Pre-and post-surgery — Support rehabilitation when surgery is the best course
- High Risk — Provide specialized care for complex MSK needs
- Women's Pelvic Health — Improve pelvic health for women at all stages of life

To be eligible for the Hinge Health programs, you and your eligible dependents must meet each of the following requirements: (i) be enrolled in a medical plan with the Hinge Health benefit, (ii) be age 18 or older, (iii) be

located in the United States, and (iv) be approved through the clinical suitability evaluation performed by Hinge Health prior to enrollment.

If you are eligible, Hinge Health is offered at no cost to you.

If you have any questions regarding Hinge Health, email help@hingehealth.com or call (855) 902-2777.

Claims and Appeals Process

For information about claims and appeals regarding The Pacific Gas and Electric Company Health Care Plan for Active Employees, see “Claims and Appeals Process” under “The Health Account Plan (HAP)”.

Employee Assistance Program (EAP)

PG&E's Employee Assistance Program (EAP), administered by Carelon Behavioral Health, provides professional counseling, consultation and referrals to help you manage life's demands. The EAP is available 24 hours a day, 7 days a week, at no cost to you and your eligible dependents. Use of the program is completely voluntary.

The following chart summarizes the EAP's services:

Employee Assistance Program (EAP)	▪ The EAP provides assistance with issues such as: ▫ Family and relationship problems ▫ Workplace concerns ▫ Alcohol and drug issues ▫ Depression and anxiety ▫ Stress at home or work ▫ Financial and legal concerns ▫ Child and adult care referrals ▪ Services include: ▫ Up to eight sessions per issue per year with a licensed EAP counselor ▫ A telephonic consultation with a financial coach ▫ A telephonic or in-person consultation with an attorney ▫ Work/Life information and referrals to community-based services for child care, adult care, adoption and more ▫ Interactive online tools and resources available from work or home For more information about legal or financial consultations or referrals, see *Work/Life Benefits.*

Eligibility and Cost

All union-represented employees who are eligible for PG&E's active medical plan are automatically eligible to receive benefits from the EAP. Additionally, such employees' eligible dependents and their household family members may receive benefits from the EAP. You do not need to be enrolled in a PG&E-sponsored medical plan to be eligible for EAP services.

Cost

There is no charge to you for EAP benefits. If additional support beyond eight EAP counseling sessions per issue per year is needed, you will be referred to your health plan administrator if you are enrolled in a PG&E medical plan, or to resources in your community if you are not enrolled in medical coverage through PG&E.

Charges for additional services, if any, are your responsibility. Mental health and substance use disorder treatment is covered by your PG&E medical plan if you and your eligible dependents are enrolled. You will be responsible for any costs not covered by your health care plan(s).

Confidentiality

Federal law mandates the privacy and security of your protected health information. The EAP upholds strict confidentiality standards. When you or your family member participates in any EAP service, your involvement is treated confidentially in accordance with all state and federal laws, and company policy. Your EAP counselor will discuss confidentiality during the first session and give you a Statement of Understanding that explains the EAP's policy in detail. HIPAA provides you with certain rights in connection with the privacy of your health information.

The EAP will not use or disclose your protected health information (PHI) for purposes other than treatment, payment or EAP administrative functions without your written authorization, as required by federal law. The EAP routinely discloses PHI to insurance companies, Benefits Administrators and other contracted health operations services such as those who verify benefits coverage or conduct audits. All PHI used, requested or disclosed is limited to the minimum amount necessary to accomplish the intended purpose of the EAP and its administration.

Circumstances Limiting Confidentiality

The EAP Statement of Understanding outlines conditions and circumstances limiting confidentiality. If you feel you cannot accept the limitations and cannot sign the Statement of Understanding, you will not be eligible to receive services through the EAP. You may, however, be able to receive benefits through your health plan.

Following is a summary of the limits to EAP confidentiality. Please note that some conditions and circumstances apply only to employees and not to dependents. Confidentiality will be limited in the following situations:

- If there is a reasonable basis to suspect child, disabled adult, or elder abuse and/or neglect; and to the extent required by state or federal law.
- If in the EAP counselor's clinical judgment, you pose an imminent danger to yourself or others.
- If release of information is compelled by law or is needed in an emergency by medical personnel for your diagnosis or treatment and you are unable to authorize disclosure.
- If you were formally referred to EAP by your supervisor, he or she may be notified only as to whether or not you have followed through in contacting EAP and are participating in the process. Your supervisor will not be given clinical information. See "Supervisory Referrals" for more information.

How to Use the Program

You may contact your local onsite EAP counselor directly – contact information can be found at mypgebenefits.com. You may also call the **EAP number at 1-888-445-4436** 24/7/365 to obtain a referral to an EAP counselor with an office near your work or home or schedule a telehealth appointment at carelonwellbeing.com/pge.

Referrals

Self-Referrals

An employee who self-initiates contact with an EAP counselor does not need to tell his or her supervisor. With the employee's consent, the counselor may contact the supervisor to arrange time off from work but will not provide information about the employee's personal concerns.

Supervisory Referrals

If you are having performance problems on the job, your supervisor may make a formal recommendation that you talk with an EAP counselor. If you choose to speak with a counselor, the counselor will not discuss your personal concerns with your supervisor. However, if you give written permission, your counselor will provide your supervisor with non-clinical information, such as whether or not you have followed through in contacting EAP and are participating in the process. Whether or not you choose to use the EAP or comply with a formal supervisor referral to EAP, you are still responsible for maintaining your job performance.

Referrals to Non-Contracted Providers

Referrals to service providers outside of Carelon Behavioral Health and/or the EAP may be recommended to help you resolve your concerns. Those services may or may not be covered under your PG&E-sponsored health care plan or that of another employer or insurer through which you may have coverage. A referral is not a guarantee that your medical plan or other provider will cover such services. It is your responsibility to determine whether or not outside services are covered under any such plan and to pay any charges that are not covered. If a referral is

made to an outside counselor under your health plan, you are encouraged to follow your health plan's procedures for obtaining proper authorization and to follow through with any authorized treatment plan.

Leaves of Absence

In the event your EAP counselor recommends a medical leave of absence for you, you are still required to notify your supervisor, call **PG&E's third party leave administrator at 1-855-732-8217** and complete all required paperwork.

Claims and Appeals Process

For information about claims and appeals regarding The Pacific Gas and Electric Company Health Care Plan for Active Employees, see "Claims and Appeals Process" under "The Health Account Plan (HAP)".

Carelon Behavioral Health of California, Inc. Grievance Protocol

Members covered under the Employee Assistance Program administered by Carelon Behavioral Health of California, Inc. (a subsidiary of Carelon Behavioral Health, Inc.), regulated by the California Department of Managed Health Care (DMCH), are entitled to receive notification of the grievance protocol.

The grievance protocol outlines standard procedures for filing a grievance with Carelon Behavioral Health of California and includes instructions for requesting expedited review of urgent grievances or requests for mediation or arbitration. You may also request an independent medical review ("IMR") of disputed Behavioral Health Care Services from the Department of Managed Health Care if you believe that behavioral health care services have been improperly denied, modified, or delayed by Carelon Behavioral Health of California.

That protocol can be found on Carelon Behavioral Health of California's website at carelonbehavioralhealthca.com. If you have any questions regarding this protocol, contact Carelon Behavioral Health of California at **1-800-228-1286** extension 262422 (TTY 1-800-735-2929).

PG&E Claims and Appeals Review Process

If you are not satisfied with the claims and grievance review process completed with Carelon Behavioral Health, you may elect to use PG&E's Voluntary Claims and Appeals Review Process (for all claims other than those relating to medical judgment, a rescission of coverage, or surprise bills (medical and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions)) , as described below, or elect to bring a civil action. You have 90 days from the date of receipt of the final decision from Carelon Behavioral Health to elect this claims and appeals review process. Initiation of the Voluntary Review Process does not restrict your ability to bring a civil action against the Plan. For claims relating to medical judgment, a rescission of coverage, or surprise bills (medical and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions), you should use the External Review process described in the preceding section.

The first step of the Claims and Appeals Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include an AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION form. You can access a copy online at mypgebenefits.com > Resources > Legal Notices, or by calling the PG&E Benefits Service Center at **1-866-271-8144**.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
Step One Appeals
300 Lakeside Drive
Oakland, CA 94612

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the Authorization form may delay your appeal). There may be special

circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

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

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

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

- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under section 502(a) of ERISA.

Medical Coverage for Participants on Long-Term Disability

The PG&E-sponsored medical plans offered to employees on Long-Term Disability (LTD) are different than the medical plans offered to Active Employees. This section describes the medical plans for LTD employees and their Eligible Dependents, which include prescription drug coverage and mental health and substance use disorder.

If you are an employee receiving benefits under the LTD Plan, your medical plan options will be one or more of the following LTD medical plans:

- the Network Access Plan (NAP), administered by Anthem Blue Cross;
- the Comprehensive Access Plan (CAP), administered by Anthem Blue Cross;
- the Kaiser Permanente Exclusive Provider Organization (Kaiser EPO) Plan; or
- the Kaiser Permanente Senior Advantage (KPSA).

The specific plan(s) that are available to you and each covered dependent will be based on your home ZIP code and each family member's Medicare-eligibility status, as described in this section. As an alternative, you may decline LTD medical coverage.

If you are transferring from the Anthem Health Account Plan (HAP) or the Kaiser HAP, your eligibility for the HAP plan will be paused. As an employee on LTD, you may continue to use your Health Account credit balance to pay for eligible health expenses; however, you will not earn any additional annual or wellness incentive Health Account credits until you resume active status as an employee and re-enroll in HAP coverage. Once you resume active status as an employee and re-enroll in HAP coverage, you will receive the annual Health Account credit allocations (at either the single or family level of coverage provided you haven't already received that year's allocation).

How Medicare Eligibility Affects Your Options

It's important to understand that PG&E's LTD medical plan options and benefits for Medicare-eligible family members differ substantially than those for family members who are not Medicare-eligible (see "LTD Medical Plan Options for Non-Medicare-Eligible Participants" and "LTD Medical Plan Options for Medicare-Eligible Participants"). For example, if you are Medicare-eligible but one or more of your enrolled dependents is not, you and your dependent(s) will receive different coverage from the medical plan carrier you select (Anthem Blue Cross or Kaiser Permanente).

In addition, if you or one of your covered dependents is eligible for Medicare while you are on LTD, Medicare will be the primary payer of medical claims for the Medicare-eligible family member(s). Therefore, it is essential that all Medicare-eligible family members are enrolled in Medicare Part B. If you and/or a Medicare-eligible family member are not properly enrolled in Medicare Part B when eligible, you will be responsible for paying the portion of your medical claims that should have been covered by Part B, which can be substantial (approximately 80% of the claims). **It is your responsibility to make sure that – once you are approved for LTD – you immediately notify the PG&E Benefits Service Center of the Medicare-eligibility status for yourself and for each family member whom you will be covering under your LTD medical plan.** In this way, PG&E can ensure that any Medicare-eligible family members are placed into the appropriate Medicare LTD plan and that claims are processed correctly. Failure to promptly notify the PG&E Benefits Service Center of a dependent's Medicare eligibility can result in that family member's medical plan being retroactively switched to the appropriate Medicare-primary plan for which he/she is actually eligible and his/her medical claims being retroactively reprocessed to pay on a secondary basis after Medicare, as explained under "Anthem Comprehensive Access Plan (CAP)" and "When You Become Medicare-Eligible."

Additional information that is pertinent to and constitutes your summary plan description for the plan benefits is included in *Rules, Regulations & Administrative Information*.

Grandfathered Health Plan Notice

The Anthem benefit options and the Kaiser EPO benefit options available to employees in 2026 are "grandfathered" benefit options under the Patient Protection and Affordable Care Act of 2010 (PPACA). They are the only grandfathered benefit plans that are available under the Health Care Plan for Active Employees.

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
300 Lakeside Drive
Oakland, CA 94612

Or, you may contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or https://dol.gov/ebsa/healthreform. This website has a table summarizing the protections that apply to grandfathered health plans.

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LTD Medical Plan Options for Non-Medicare-Eligible Participants

The table below summarizes the LTD medical plan options available to LTD employees and/or their dependents who are *not* eligible for Medicare, and a reference to where more details about each plan can be found.

Medical Coverage (Plan eligibility depends on home ZIP code)	***Anthem Blue Cross-Administered plans*** *(Eligibility depends on home ZIP code)* ▪ Network Access Plan (NAP) ▪ Comprehensive Access Plan (CAP) ***Kaiser Permanente*** *(Must live within the Kaiser Permanente EPO service territory)* ▪ Kaiser Exclusive Provider Organization (EPO) Plan – Northern and Southern California
Mental Health and Substance Use Disorder (Automatically included with medical plan coverage)	***For NAP and CAP Members:*** ▪ Coverage provided through Carelon Behavioral Health ***For Kaiser EPO Members:*** ▪ Coverage provided through Kaiser Permanente, except for Inpatient Substance Use Disorder, which is covered through Carelon Behavioral Health. Detoxification and Applied Behavioral Analysis (ABA) are available through both Kaiser and Carelon Behavioral Health.
Prescription Drugs (Automatically included with medical plan coverage)	***For NAP and CAP Members:*** ▪ Express Scripts (retail) ▪ Express Scripts Mail-Order Pharmacy (mail-order) ***For Kaiser EPO Members:*** ▪ Drug coverage (retail and mail-order) through Kaiser Permanente (call Kaiser Permanente member services number for details).

Plans Administered by Anthem Blue Cross

All employees on LTD and their Eligible Dependents who are not eligible for Medicare are eligible for one of the following two PG&E-sponsored LTD medical plans administered by Anthem Blue Cross:

- the Network Access Plan (NAP); or
- the Comprehensive Access Plan (CAP).

If you elect a plan administered by Anthem, non-Medicare-eligible family members will be enrolled in either the NAP or CAP, depending on your home ZIP code. Any family members who are eligible for Medicare will be enrolled in the CAP (see "Anthem Comprehensive Access Plan (CAP)"). The Anthem plan(s) for which you are eligible will be shown on your Personal Enrollment Worksheet (PEW). Make sure you have notified the PG&E Benefits Service Center of the correct Medicare eligibility status for you and each covered dependent so that the correct LTD medical plan options are offered to you and displayed on your PEW. It is ultimately your responsibility to properly notify PG&E if you or any dependents are eligible for Medicare, so that each family member is offered and placed into the correct type of plan (Medicare or non-Medicare).

The NAP or CAP will provide primary medical plan coverage for your family members who are not eligible for Medicare. Medical coverage under the CAP for Medicare-eligible family members will be secondary to Medicare, as explained under "Anthem Comprehensive Access Plan (CAP)."

PG&E LTD Plans Administered by Anthem Blue Cross	Available for Non-Medicare-Eligible Members?	Available for Medicare-Eligible Members?	Available in All Locations?
Network Access Plan (NAP)	Yes	No	No
Comprehensive Access Plan (CAP)	Yes	Yes (members must be enrolled in Medicare Parts A and B)	**Non-Medicare-Eligible Participants:** No, available only in areas where NAP is not offered **Medicare-Eligible Participants:** Yes

Kaiser Exclusive Provider Organization (EPO) Plan

If you live in the Kaiser Permanente EPO service territory, in addition to being offered the Anthem-administered NAP and/or CAP, the Kaiser EPO Plan will be an option for your family members who are not eligible for Medicare. If you live in a service area where the Kaiser EPO is offered, the plan will appear as an option on your Personal Enrollment Worksheet (PEW). If you elect the Kaiser EPO Plan, family members who are eligible for Medicare must enroll in the Kaiser Senior Advantage Plan, which is a Medicare Advantage HMO plan. Special rules apply to Kaiser Senior Advantage; for more information, see "Kaiser Senior Advantage Plan." Make sure you have notified the PG&E Benefits Service Center of each family member's correct Medicare status so that the correct LTD medical plan options are offered to you and displayed on your PEW. It is ultimately your responsibility to properly notify PG&E if you and any dependents are eligible for Medicare, so that your family members are each offered/placed into the correct type of medical plan (Medicare or non-Medicare).

The Kaiser EPO Plan may not be available throughout an entire county; precise service areas are specified by home ZIP code. Because of the ongoing nature of service territory changes, we recommend that you verify the service area and provider availability directly with Kaiser. In addition, please note that not all ZIP codes that offer the Kaiser EPO Plan also offer Senior Advantage. If you or any of your family members are eligible for Medicare, call Kaiser Permanente before enrolling to make sure that Senior Advantage is also offered in your ZIP code.

If You Are Not Medicare-Eligible, But an Enrolled Dependent Is

If any of the dependents you cover are over age 65 and/or under age 65 and Medicare-eligible due to disability, they will be enrolled in the Medicare version of the plan you elect, as indicated below, if available in your area based on your home ZIP code.

It's your responsibility to notify the PG&E Benefits Service Center when you or a dependent become eligible for Medicare.

If you are enrolled in:	Your Medicare-eligible dependent(s) will be enrolled in:
Anthem Network Access Plan (NAP)	Anthem Comprehensive Access Plan (CAP)
Anthem Comprehensive Access Plan (CAP)	Anthem Comprehensive Access Plan (CAP)
Kaiser EPO (North or South)	Kaiser Senior Advantage North or South (Medicare Advantage HMO)

For Kaiser EPO Members: Kaiser Permanente requires any Medicare-eligible dependent(s) to enroll in and assign their Medicare benefits to Kaiser Senior Advantage, Kaiser's Medicare Advantage HMO. If you enroll in the Kaiser EPO Plan, your covered dependents who are eligible for Medicare must enroll in the coordinating Medicare Kaiser Senior Advantage Plan, which authorizes assignment of their Medicare benefits to the Kaiser Senior Advantage

and enrollment in Senior Advantage's Part D Prescription Drug Plan. To enroll, your dependent must obtain their Medicare number, Medicare Part A enrollment date and Medicare Part B enrollment date. Once all the necessary information is obtained, you may complete your enrollment in PG&E's Benefits Portal.

If your Medicare-eligible dependent does not have Medicare Part A and B and/or does not complete the Senior Advantage enrollment in a timely manner, he or she cannot enroll in Senior Advantage and instead will be automatically placed into the Comprehensive Access Plan (CAP), administered by Anthem Blue Cross. Furthermore, because employees and their enrolled dependents cannot be covered by different medical plan carriers, if your dependent is switched to the Anthem CAP because they did not properly enroll in Kaiser Senior Advantage, you will also be switched to the appropriate non-Medicare Anthem plan offered in your area (either NAP or CAP, depending on your ZIP code), and you will be responsible for the Anthem plan's premium.

LTD Medical Plan Options for Medicare-Eligible Participants

The following table summarizes the LTD medical plan options available to LTD employees and/or their dependents who are Medicare-eligible, and a reference to where more details about each plan can be found.

Health Care Benefits	LTD Medical Plan Options for Medicare-Eligible Participants
Medical Coverage	▪ Comprehensive Access Plan (CAP), administered by Anthem Blue Cross ▪ Kaiser Permanente Senior Advantage – Northern and Southern California (*Medicare Advantage Plan*) *(*must live within the Kaiser Permanente EPO service territory*)*
Mental Health and Substance Use Disorder (Automatically included with medical plan coverage)	***For Anthem CAP Members:*** ▪ Coverage provided through Carelon Behavioral Health ***For Kaiser Senior Advantage Members:*** ▪ Coverage provided through Kaiser Permanente, except for Inpatient Substance Use Disorder, which is covered through Carelon Behavioral Health. Detoxification and Applied Behavioral Analysis (ABA) are available through both Kaiser and Carelon Behavioral Health.
Prescription Drugs (Automatically included with medical plan coverage)	***For Anthem CAP Members:*** ▪ Express Scripts (retail) ▪ Express Scripts Mail-Order Pharmacy (mail-order) ***For Kaiser Senior Advantage Members:*** ▪ Medicare Part D Plan; prescription drug coverage (retail and mail-order) through Kaiser Permanente (call Kaiser Permanente member services number for details)

Anthem Comprehensive Access Plan (CAP)

The Comprehensive Access Plan (CAP), administered by Anthem Blue Cross, is a self-funded medical plan available to Medicare-eligible employees on LTD and their Medicare-eligible dependents, regardless of where they live. This plan provides Medicare secondary coverage, plus primary prescription drug coverage, to Medicare participants. This means Medicare processes your claims first (except prescription drugs claims), and the CAP pays only the difference necessary to make your total reimbursement (Medicare's payment plus the CAP's payment) equivalent to the same benefit a non-Medicare member would receive. You still may be required to pay part of the claim.

If you are Medicare-eligible and enroll in the CAP, any enrolled dependents who are not Medicare-eligible will be enrolled in the non-Medicare version of the plan in which you are enrolled (either the NAP or CAP, depending on your home ZIP code), and Anthem Blue Cross will remain the primary payer for their non-Medicare claims. However, if an enrolled dependent becomes Medicare-eligible at any point while you are on LTD, the dependent will need to sign up for Medicare Parts A and B and be switched to the Medicare CAP as of their Medicare Effective Date. It is your responsibility to make sure that your dependent signs up for Medicare Parts A and B

immediately upon becoming eligible for Medicare, since Medicare Parts A and B will become the primary payer of your dependent's medical claims at that time, and the Anthem CAP will only pay on a secondary basis as of your dependent's Medicare Effective Date.

When you are Medicare-eligible, the Plan requires Anthem Blue Cross to assume you are enrolled in both Part A and Part B of Medicare and to pay benefits accordingly (i.e., on a secondary basis after Medicare). Anthem Blue Cross makes this assumption even if you do not apply for the Medicare benefits to which you are entitled. Therefore, to maximize reimbursement and avoid unpaid claims, ***you and/or your dependents must enroll in both Part A and Part B of Medicare when you first become Medicare-eligible.***

Under the CAP**, when Medicare is the primary payer**, claims should be submitted to Medicare first and then to Anthem Blue Cross along with copies of the "Explanation of Medicare Benefits" (EOMB) statements which indicate how much Medicare has paid. If you do not enroll in Medicare when eligible, benefits from these plans will be reduced by the amount Medicare would have paid had you been enrolled in Medicare. If you would like to avoid having to submit claims to both Medicare and Anthem Blue Cross, you can call Anthem Blue Cross Member Services and ask for a "Medicare Crossover" form. By completing this form, you are directing Medicare to electronically forward claims to Anthem Blue Cross for further processing, once Medicare has done its initial processing.

How the CAP Integrates with Medicare: Two Examples

The following examples assume that:

- You have paid your annual deductible for Medicare Part B, and you have met your calendar year deductible on the CAP Plan
- The CAP Plan benefit for surgical expenses is 100%
- Physician's billed charges for surgical procedure are $4,370
- Medicare's "allowed" amount for this service is $3,800
- Medicare pays 80% of the allowed amount, which equals $3,040

Example #1: Physician accepts Medicare assignment as payment in full	
Covered charges (Medicare allowed amount)	$3,800
CAP Plan benefit	$3,800
Medicare pays 80% of allowed amount	$3,040
CAP Plan pays	$760
Total paid to physician (physician agrees to accept $3,800 as payment in full)	$3,800
You pay	$0

Example #2: Physician does not accept Medicare assignment as payment in full	
Physician's billed charges for service (up to 115% of Medicare allowed amount)	$4,370
Covered charges (Medicare allowed amount)	$3,800
CAP Plan benefit	$3,800
Medicare pays 80% of allowed amount	$3,040
CAP Plan pays	$760
Total paid to physician	$3,800
You pay	$570

Note: When a physician does not accept Medicare assignment as payment in full, you are responsible for the difference between the physician's billed charges (up to 115% of Medicare's allowed amount) and Medicare's allowed amount. If the physician bills more than 115% of Medicare's allowed amount, that amount is considered a provider write-off.

Kaiser Senior Advantage Plan

The Kaiser Senior Advantage Plan is only available to Medicare-eligible participants. You must be enrolled in both Parts A and B of Medicare and live in the Kaiser Permanente Senior Advantage service area to be eligible for the Plan; please note that Senior Advantage may not be available in all areas where the Kaiser EPO Plan is offered.

Kaiser Senior Advantage requires you to seek coverage through Kaiser Permanente's network of physicians and hospitals and requires that you assign or "give away" your Medicare benefits to the Plan. By doing so, you can no longer use your Medicare benefits outside of the Kaiser Permanente network. To enroll, you must enroll in Medicare Parts A and B—even if you elect PG&E-sponsored medical coverage.

There are three ways you can enroll in Medicare Parts A and B:

1. Call the **Social Security Administration** at **1-800-772-1213**.
2. Visit your local Social Security office.
3. Enroll online by visiting **medicare.gov**.

Once you complete your Medicare enrollment, you'll receive your Medicare Number and your Medicare A and B Enrollment Dates. These are required to complete your enrollment for the PG&E medical plans via the PG&E Benefits Portal or by calling the **PG&E Benefits Service Center** at **1-866-271-8144**.

If you do not have Medicare Part ***A and B*** and/or you do not complete the automated Medicare enrollment process (AME) in a timely manner, you cannot enroll in Senior Advantage and instead will be automatically placed in the Comprehensive Access Plan (CAP), administered by Anthem Blue Cross. Furthermore, because employees and their enrolled dependents must be covered by the same medical plan carrier, if you or a dependent is switched to the Anthem CAP because you did not have Medicare Parts A and B or because you do not complete the AME process prior to the effective date of coverage, you and any enrolled family members will also be switched to the appropriate Anthem plan offered in your area (NAP or CAP, depending on your ZIP code, for non-Medicare-eligible family members, and the CAP for Medicare-eligible family members), and you will be responsible for paying the Anthem plan's premium.

When you enroll in Kaiser Senior Advantage, you will automatically be enrolled in Kaiser Permanente's Part D prescription drug coverage, which is included as part of your Kaiser Senior Advantage Plan benefits. The Part D coverage is considered an "enhanced" Part D plan. This means the Plan has better benefits than a standard Medicare Part D Plan, without any deductibles or gaps in coverage. While enrolled in the Kaiser Senior Advantage Part D drug benefit, you will not be allowed to enroll in any other Medicare Part D Prescription Drug Plan (PDP) outside of Senior Advantage. Enrolling in an external PDP outside of your PG&E-sponsored Senior Advantage coverage will cause you to be dropped from your PG&E medical plan.

If you wish to change plans or drop Company-sponsored medical plan coverage at some future date, you will need to fill out a Kaiser Senior Advantage Disenrollment Form so that Kaiser can release your Medicare benefits back to you. Call the **PG&E Benefits Service Center** at **1-866-271-8144** for more information and/or the appropriate form.

For more information about the Kaiser Senior Advantage Plan, see *Kaiser Senior Advantage Plan*.

If You Are Medicare-Eligible, But an Enrolled Dependent Is Not

If any of the dependents you cover are under age 65 and not Medicare-eligible, they will be enrolled in the non-Medicare version of the plan you elect, as indicated below, and if available in your area based on your home ZIP code.

If you are enrolled in:	Your dependent(s) not Medicare-Eligible will be enrolled in:
Comprehensive Access Plan (CAP)	Anthem Network Access Plan (NAP) or Anthem Comprehensive Access Plan (CAP) (depending upon where you live)
Kaiser Senior Advantage North or South (Medicare Advantage HMO)	Kaiser EPO Plan (North or South)

Medicare

For most individuals, Medicare Parts A, B, and D benefits currently become available at the beginning of the month in which a person reaches age 65. Medicare Parts A, B, and D benefits usually become available to individuals before age 65 in certain circumstances, including when the individual has been receiving Social Security Disability Insurance (SSDI) benefits for at least two years or has End-Stage Renal Disease (ESRD).

For Pacific Gas and Electric Company employees on LTD, the Company has retained the services of Allsup, Inc. to assist participants under age 65 and their dependents under age 65 in applying for SSDI benefits and enrolling in Medicare. These services are provided at no cost. If you or any covered dependents are disabled and under age 65, you can call Allsup, Inc. at **1-888-339-0743** to request assistance.

In addition, the Company reimburses disabled retirees and survivors who are under age 65 for the standard monthly Medicare Part B premiums. See “Medicare Part B.”

Medicare Part A

Part A is hospital insurance. It covers hospitalization, home health care, hospice care and stays in skilled nursing facilities, as long as the care is not considered custodial. You pay for coverage in Part A through payroll taxes during your working career; generally, no additional premiums are required for Part A, unless you did not earn enough credits to qualify.

Medicare Part B

Part B is supplementary medical insurance that covers professional fees (such as doctor’s office visits and outpatient services/surgery) and related expenses. Unlike Part A, you must pay monthly premiums toward membership in Part B. The monthly premium is automatically deducted from your Social Security check. By enrolling when you are first eligible, you can minimize your Part B premium. If you enroll late or if you drop out and enroll again at a later date, your Part B premium increases 10% for every 12 months you do not participate. The Company reimburses the standard monthly Medicare Part B premiums for any under age-65 covered dependents of employees on LTD, as long as the dependents are enrolled in Medicare Parts A and B.

The Company-sponsored medical plans require that you enroll in Medicare Part B, if eligible, and maintain your Part B premiums. If you do not, the only PG&E-sponsored plan that you will be eligible to enroll in is the

Comprehensive Access Plan (CAP); however, the benefits you receive from the CAP Plan will be greatly reduced if you have not enrolled in Medicare. To help offset the cost of Part B premiums, the Company will provide LTD employees with a Medicare Refund Credit. See "Coordination with Medicare" for more details.

Medicare Part D

Medicare Part D is a prescription drug benefit. If you enroll in the Kaiser Senior Advantage Medicare Advantage HMO, you will be also enrolling in an enhanced Medicare Part D plan. If you enroll in the Comprehensive Access Plan (CAP) administered by Anthem Blue Cross, you will not be enrolling in a Part D plan. However, since CAP has prescription drug benefits equal to or better than the minimum Part D benefit, you will be treated by Medicare as if you had been enrolled in a Part D plan and you will not be assessed a premium penalty for late Part D enrollment if you decide later to enroll in a Part D plan. Whether you enroll in Kaiser Senior Advantage or CAP, you will receive the benefit of lower medical premiums, because the Company passes on the savings that it receives on Medicare Part D to its members.

Every year, the Company provides a Creditable Coverage notice to all medical plan participants. The notice attests that the Company-sponsored medical plan prescription drug benefits are actuarially equal to or better than the Medicare Part D basic benefit. You should keep the notice because it provides protection against Medicare Part D late enrollment penalties should you sometime in the future drop Company-sponsored medical plan coverage and enroll in a Medicare Part D plan. For a copy of the notice or additional information, you can contact the **PG&E Benefits Service Center** at **1-866-271-8144**.

All Medicare beneficiaries have the option of enrolling in many different Medicare-approved Part D plans, called Prescription Drug Plans (PDPs), offered outside of the Company (for example, at your local chain drugstore). While it is your choice whether you decide to enroll in one of these external PDPs, it's extremely important that you consider this decision carefully. **If you enroll in Medicare Part D though an external PDP** (i.e., not through the Company's enrollment process), **you will lose your Company-sponsored medical plan and prescription drug coverage**.

When You Become Medicare-Eligible

Generally, you become Medicare-eligible as of the first of the month in which you reach age 65, whether or not you are retired. If your birthday is on the first of any month, you become Medicare-eligible on the first of the prior month. You become eligible before age 65 in certain circumstances, including if you have been receiving Social Security Disability Insurance (SSDI) benefits for two years or if you have chronic kidney disease (End Stage Renal Disease, or ESRD). In addition, your non-working spouse may become Medicare-eligible when he or she turns age 65 based on your work record, as long as you are at least age 62. While you are on LTD, all family members who are or become eligible for Medicare due to age, disability or ESRD ***must*** enroll in Medicare Parts A and B immediately to receive full coverage under any PG&E LTD medical plan.

Although PG&E's enrollment records indicate when you or a dependent becomes eligible for Medicare due to turning age 65, the Company generally will not know when you or a family member becomes entitled to early Medicare due to disability or ESRD. Therefore, if you or a dependent becomes eligible for early Medicare due to disability/ESRD prior to age 65, **you must immediately notify the PG&E Benefits Service Center of the change in Medicare eligibility status and ensure that you and/or your dependents are properly enrolled in Medicare Parts A and B.** Promptly notifying the PG&E Benefits Service Center of the change will ensure that all family members are properly switched to the appropriate Medicare LTD medical plan (CAP or Kaiser Senior Advantage) and that your family member's medical claims are being correctly coordinated with your Medicare-primary plan. Failure to properly notify the Company of a family member's Medicare eligibility can result in retroactive corrections being made to your PG&E medical plan enrollment and the retroactive reversal of primary claims payments that were inappropriately made on behalf of Medicare-eligible family members. In addition, promptly signing up for Parts A and B is necessary to ensure that you have full coverage under your PG&E medical plan and that you are not without primary medical coverage. Most importantly, since your PG&E plan does not cover expenses that should have been paid by Medicare, if you are not properly enrolled in Medicare Parts A and B when eligible, you will be responsible for paying the portion of your claims that should have been paid by Medicare Parts A and B, which can be substantial (usually 80% of the Medicare-allowed amount). Claims that are inappropriately processed on a primary basis by your PG&E plan will be retroactively reversed for a period of up to 12 months.

Anthem Network Access Plan (NAP) (Available only to employees on Long-Term Disability)

Eligibility for the Anthem Network Access Plan (NAP) — a Preferred Provider Organization (PPO) plan — is dependent upon your Medicare-eligibility status and where you live. The plan is only available to employees on Long-Term Disability (LTD) and their eligible dependent(s). Anthem Blue Cross on behalf of Anthem Blue Cross Life & Health Insurance Company (Anthem Blue Cross Life & Health) is the Claims Administrator. The Claims Administrator is referred to as "Anthem Blue Cross" or "Anthem" in this document.

Important Information

For additional important information about the Anthem Blue Cross-administered NAP, see *Glossary for LTD Plans* and *Claims and Appeals Process for the Anthem NAP and Anthem CAP*.

Only participants who are not eligible for Medicare can enroll in the NAP. If you and/or your eligible dependent(s) are not eligible for Medicare and your home ZIP code meets the following access criteria, you are eligible to enroll in the Network Access Plan (NAP). If you and/or your eligible dependent(s) are eligible for Medicare or if your home ZIP code does not meet the criteria below, you are instead eligible to enroll in the Comprehensive Access Plan (CAP). See "Anthem Comprehensive Access Plan (CAP)" for further details on that plan.

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

For assistance in locating a NETWORK PROVIDER in your area or to obtain a Prudent Buyer Plan PPO network provider directory, contact **Anthem Blue Cross Member Services** at **1-800-964-0530**. You may also visit the Anthem Blue Cross website at anthem.com and select the Prudent Buyer Network option.

NAP at a Glance

This is a summary of the Network Access Plan (NAP) benefits. Please refer to "What the NAP Covers" for more information on covered services and exclusions.

The information in this chart is intended to be a summary of the benefits provided by the NAP as of January 1, 2026. The information contained in the Pacific Gas and Electric Company Health Plan Document shall govern in case of conflict between this chart and the plan document. Please refer to the most recent information about your medical plan benefit options, which are updated annually in the Open Enrollment materials.

Provisions	Network	Non-Network
General	Care provided by NETWORK PROVIDERS. Annual Deductible: ▪ $120/person; $240/two people; $320/three or more people Annual out-of-pocket maximum (includes deductible): ▪ $750/person, no more than $1,500/family ▪ No lifetime benefits maximum ▪ No preexisting condition exclusions.	Care provided by NON-NETWORK PROVIDERS. Annual Deductible: ▪ $240/person; $480 /two people; $680/three or more people Annual out-of-pocket maximum (includes deductible): ▪ $1,000/person, no more than $2,000/family No lifetime benefits maximum. No pre-existing condition exclusions.
	▪ All plan benefits and out-of-pocket maximums are based on ELIGIBLE EXPENSES only. For the definition of "Eligible Expenses," see *Glossary for LTD Plans*. ▪ Network benefits and limits may not be combined with non-network benefits and limits.	
Hospital Stay	100% after $100 copay; pre-authorization required for non-emergency care, $300 penalty if not obtained; covers semi-private room (private if Medically Necessary); includes intensive care.	70%; pre-authorization required for non-emergency care, $300 penalty if not obtained; covers semi-private room (private if Medically Necessary); includes intensive care.
Skilled Nursing Facility (For more information on custodial care, see "Skilled Nursing Facility")	90% for semi-private room after 3 days in HOSPITAL; pre-authorization required, $300 penalty if not obtained. Excludes custodial care.	70% for semi-private room after 3 days in hospital; pre-authorization required, $300 penalty if not obtained. Excludes custodial care.
Emergency Room	$35 copay/visit for medical emergencies; waived if admitted. Lab/X-ray covered separately.	$35 copay/visit for medical emergencies; waived if admitted. Lab/X-ray covered separately.

Provisions	Network	Non-Network
Outpatient Hospital Care	$35 copay/visit for outpatient surgery; waived if admitted. Lab/X-ray covered separately	70% for outpatient care, including outpatient surgery.
Maternity Care	Covered as any other condition. Pre-authorization required for delivery stays beyond 48 hours for normal delivery (96 hours for cesarean section); $300 penalty if not obtained.	Covered as any other condition. Pre-authorization required for delivery stays beyond 48 hours for normal delivery (96 hours for cesarean section); $300 penalty if not obtained.
Well-Baby Care	Covered as any other condition.	Covered as any other condition.
Office Visits	▪ Primary care $10 copay/visit ▪ Specialist (including OB/GYN) –$20 copay/visit. ▪ Lab/X-ray covered separately	70%
Telemedicine	Primary care telemedicine visits with Anthem network providers are covered under the NAP. Coinsurance for primary care or specialty telemedicine visits is the same as for in-person visits. LiveHealth Online LiveHealth Online is a telemedicine service that allows PG&E employees to engage in a "virtual office visit" with a board-certified doctor, psychiatrist, or licensed therapist via a live video/audio conference in a HIPAA-secure environment. You can use LiveHealth Online anywhere and anytime. ▪ LHO Primary care - $10 copay/visit ▪ LHO Specialist - $20 copay/visit All you have to do to get started is register. LiveHealth Online can be accessed 24/7 from any computer or mobile device that has a high-speed Internet connection and a webcam. It's like a virtual office that you can use when you're sick, experiencing something minor like a rash, you need help with anxiety or depression, or when you need a prescription. To access LiveHealth Online via your personal computer, register at LiveHealthOnline.com, or download the app to get started on a mobile device. For additional information about **Anthem's telemedicine program**, please refer to the LiveHealth Online FAQs, email **customersupport@livehealthonline.com**, or call **1-855-603-7985**.	

Provisions	Network	Non-Network
Urgent Care Visits	▪ Primary care $10 copay/visit ▪ Specialist (including OB/GYN) –$20 copay/visit. ▪ Lab/X-ray covered separately	70%
Routine Physical Examinations	▪ Primary care –$10 copay/visit ▪ Specialist –$20 copay/visit ▪ Lab/X-ray covered separately.	70%
Immunizations and Injections	95%	70%
Routine Eye Examinations	Not covered.	Not covered.
X-rays and Lab Tests	90%	70%
Pre-Admission Testing	95%	70%
Home Health Care and Home Hospice Care (For more information on custodial care, see "Home Health Care and Hospice Care")	90%; requires prior authorization; $300 penalty if not obtained. Excludes custodial care.	70%; requires prior authorization; $300 penalty if not obtained. Excludes custodial care.
Outpatient Physical Therapy	80%	70%
Outpatient Prescription Drugs	Covered by separate drug plan administered by Express Scripts. See *Prescription Drug Coverage for the NAP and CAP*.	Covered by separate drug plan administered by Express Scripts. See *Prescription Drug Coverage for the NAP and CAP*.
Inpatient and Outpatient Mental Health Care	Covered by separate Mental Health Program administered by Carelon Behavioral Health. See *Mental Health and Substance Use Disorder Coverage for LTD Plans*.	Covered by separate Mental Health Program administered by Carelon Behavioral Health. See *Mental Health and Substance Use Disorder Coverage for LTD Plans*.
Inpatient and Outpatient Substance Use Disorder Care	Covered by separate Substance Use Disorder Program administered by Carelon Behavioral Health. See *Mental Health and Substance Use Disorder Coverage for LTD Plans*.	Covered by separate Substance Use Disorder Program administered by Carelon Behavioral Health. See *Mental Health and Substance Use Disorder Coverage for LTD Plans*.
Durable Medical Equipment	80%; pre-authorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained.	70%; pre-authorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained.

Provisions	Network	Non-Network
Hearing Aids and Cochlear Implants	▪ 80% for hearing aids and exams to determine the need for hearing aids or the need to adjust them. ▪ 80% for cochlear implants for adults and children (age 2 or older), for the following diagnoses: (1) severe to profound bilateral sensorineural hearing loss and severely deficient speech discrimination; or (2) post-lingual deafness in an adult. Hearing aid hardware is limited to one hearing aid per ear every three years.	▪ 80% for hearing aids and exams to determine the need for hearing aids or the need to adjust them. ▪ 70% for cochlear implants for adults and children (age 2 or older), for the following diagnoses: (1) severe to profound bilateral sensorineural hearing loss and severely deficient speech discrimination; or (2) post-lingual deafness in an adult. Hearing aid hardware is limited to one hearing aid per ear every three years.
Chiropractic Care	80% for care approved by American Specialty Health Network (ASHN) using network provider. See "Chiropractic Care."	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.
Services Received Outside of the US	Limited to urgent/emergency services only	Limited to urgent/emergency services only
Other Benefits	INFERTILITY Treatment—Paid according to type of benefit; $7,000 lifetime maximum. Balances from prior plans carry forward. Transplant Services—100% when performed at a Center of Medical Excellence (CME); 70% when performed at a non-CME, Network facility; pre-authorization required.	Infertility Treatment—Paid according to type of benefit; $7,000 lifetime maximum. Balances from prior plans carry forward. Transplant Services—Not covered.

How the NAP Works

Anthem Blue Cross is the Claims Administrator for the NAP. The NAP offers you a choice each time you seek medical care. You may:

- obtain medical care through a NAP NETWORK PROVIDER and receive network benefits, or
- obtain medical care through any provider you choose and receive lower non-network benefits if the provider does not participate in the network.

Network Providers

The NAP provides in-network coverage through a preferred provider organization, or "PPO." A PPO consists of a network of doctors, hospitals, laboratories and other providers who have agreed to provide services based on a NEGOTIATED RATE for each service. NAP members may go directly to any provider or specialist of your choice without PRE-AUTHORIZATION from a primary care PHYSICIAN (PCP). The plan encourages the use of the Anthem Blue Cross Prudent Buyer Plan PPO network by offering a higher level of reimbursement when members use NETWORK PROVIDERS. If you receive care from a network provider who charges more than the negotiated rate, you will be held harmless for those charges above the negotiated rate. Similarly, if a network provider has referred you to a NON-NETWORK PROVIDER, you will not be responsible for fees over the maximum allowed amount.

Inside California

The NAP uses the Anthem Blue Cross Prudent Buyer Plan PPO network in California. You can locate network providers by calling Anthem Blue Cross directly or by visiting its website.

Outside of California, But Within the United States

Outside of California, the Plan uses the BlueCard PPO network of providers across the country who have agreed to provide services at negotiated rates. These providers participate in one of the local Anthem Blue Cross Blue Shield plan PPO networks and are available to you through the BlueCard Program, but do not contract directly with Anthem Blue Cross. Also available are traditional providers who might not participate in a BlueCard PPO network but have agreed to provide PPO members with health care services at a discounted rate. To locate BlueCard PPO providers, you may:

- call Anthem Blue Cross Member Services at **1-800-964-0530**; or
- visit the Anthem Blue Cross website at **anthem.com**.

Outside of the United States

- Outside of the United States, only emergency/URGENT CARE is covered. See "While Traveling Away From Home."

Non-Network Providers

Under the Plan, you may also go to any non-network doctor or HOSPITAL at any time. However, these doctors and hospitals do not participate in the Prudent Buyer PPO network and have not agreed to NEGOTIATED RATES. If you seek care from a provider who does not participate in the network, you receive reimbursement at a lower level.

If you receive treatment from a doctor who does not participate in the Prudent Buyer Plan PPO network, you may be responsible for any amounts over the maximum allowed amount. These amounts can be substantial. You should discuss this with your physician.

Please remember, you have a responsibility to work together with the PHYSICIAN(S) you select to ensure that all your medical needs are appropriately met, and to notify Anthem's Medical Management Program when pre-authorization is required. (See "Medical Management Programs Under the NAP and CAP" for more information.)

Continuity of Care

You may have to find a new Provider or health care facility when:

- the Plan's network changes and the Provider or facility you have is not in the new network; or
- you are already enrolled in the Plan and your Provider or facility stops participating in the Plan's network.

However, in some cases, you may be able to keep going to your current Provider or facility to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. A continuing care patient is an individual who is undergoing treatment for one of the following:

- a serious and complex condition;
- institutional or inpatient care;
- pregnancy;
- terminal illness; or
- a scheduled non-elective surgery.

Routine procedures, minor illnesses, and elective surgical procedures generally are not covered under this continuity of care provision.

If you qualify as a continuing care patient, the Plan will notify you, and you will be given the opportunity to submit a request for continuity of care. If your request is approved, you will generally be entitled to continue your care, subject to the same terms and conditions that applied when your Provider or facility was in the Plan's network, until the earlier of: (1) the end of a 90-day period that begins on the date you receive notice that you qualify as a

continuing care patient, or (2) the date on which you are no longer a continuing care patient with respect to that Provider or facility.

Deductibles

The annual deductible is the amount you must pay before the Plan starts paying for benefits.

	Network	Non-Network
One Person	$120	$240
Two People	$240	$480
Three or More People	$320	$680

Charges for non-covered services, penalties for not obtaining authorization, amounts over the maximum allowed amount, and flat dollar copayments (for example, for doctor's office visits, emergency room visits, or HOSPITAL admissions) do not apply toward the annual deductible.

Examples of How Copayments Work With the Annual Deductible

(Assuming NAP Member Uses NETWORK PROVIDERS for All Three Office Visits)

Visit #1 to Primary Care Physician: Provider charges $100 for the office visit. The claim will be paid as follows:	Network Provider
Total Billed	$100
Amount Allowed for a PPO network participating provider (based on the negotiated discount)	$75
Primary Care PHYSICIAN Office Visit Copay	$10
Amount Applied to Calendar Year Deductible	$65
Calendar Year Deductible Remaining To be Met	$55
Amount Paid by the Plan	$0
Total Member Responsibility for this Visit	$75

Visit #2 to OB/GYN Specialist: Provider charges $150 for the office visit. The claim will be paid as follows:	Network Provider
Total Billed	$150
Amount Allowed for a PPO network participating provider (based on the negotiated discount)	$100
Specialist Office Visit Copay	$20
Allowed Amount Remaining After Copay	$80
Amount Applied to Remaining Calendar Year Deductible which is Now Met	$55
Amount Paid by the Plan	$25
Total Member Responsibility for this Visit	$75

Visit #3 to Dermatology Specialist: Provider charges $165 for the office visit. The claim will be paid as follows:	Network Provider
Total Billed	$165
Amount Allowed for a PPO network participating provider (based on the negotiated discount)	$125
Specialist Office Visit Copay	$20
Allowed Amount Remaining After Copay	$105
Amount Paid by the Plan	$105
Total Member Responsibility for this Visit	$20

Plan Maximums

Out-of-Pocket Maximums

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

	Network Providers	Non-Network Providers
Per Person	$750	$1,000
Family	$1,500	$2,000

Charges for non-covered services, charges above the maximum allowed amount (ELIGIBLE EXPENSES), and penalties for not obtaining pre-authorization do not apply toward the annual out-of-pocket maximum.

Lifetime Maximums

The Plan does not have an overall lifetime maximum benefit, but there are lifetime maximums for the following services or supplies:

Service or Supply	Lifetime Maximum
INFERTILITY Treatments	$7,000 combined for all PG&E self-insured medical plans administered by Anthem Blue Cross or prior claims administrators.
Reimbursement for Travel and Lodging Expenses incurred in connection with Organ Transplants Transportation and lodging expenses for the transplant recipient and companion(s)	$10,000 combined for all travel expenses.
Reimbursement for Travel and Lodging Expenses incurred in connection with Bariatric/Gender-Affirming Surgery	$3,000 combined for all travel expenses.

Copayments and Benefit Percentages

The plan's coinsurance (percentage coverage) does not begin until after the annual deductible has been met. All copayments apply before the annual deductible. The copayments and percentages of reimbursement are listed under the Summary of NAP Benefits.

ELIGIBLE EXPENSES will be reimbursed based on NEGOTIATED RATES for NETWORK PROVIDERS and the maximum allowed amount for NON-NETWORK PROVIDERS, after any copayments and after meeting the annual deductible. If your non-network provider bills an amount above the maximum allowed amount (Eligible Expenses), you will be responsible for paying this difference along with your coinsurance. Network providers have agreed not to charge you more than the negotiated rate, so you will not be responsible for any amount in excess of the negotiated rate for Covered Health Services when you use a network provider.

Copayment for Emergency Room and Outpatient Surgery

The NAP provides coverage for outpatient HOSPITAL services including outpatient surgery, radiation therapy, chemotherapy and hemodialysis. For outpatient hospital emergency room visits, you must pay a $35 copayment for each visit. Your $35 copayment will not be applied to your annual deductible; however, it will count toward your annual out-of-pocket maximum (see "Plan Maximums"). For in-network outpatient hospital surgery NAP pays at 100% after $35 copay and non- network outpatient hospital surgery pays at 70% of the maximum allowed amount after your deductible. Please note that any outpatient lab work and/or X-rays you receive are covered separately after the deductible at 90% in-network and 70% out-of-network.

Physician Office Visit Copayment

Benefits are provided for primary care PHYSICIAN office visits for illness or disease after you pay a $10 copayment per in-network visit and meet your annual deductible. The in-network copayment for a specialist visit is $20. No referral from your primary care physician will be required in order for you to see your specialist. The office visit copayment does not apply to the annual deductible; however, it will count toward your annual out-of-pocket maximum. If you go to a non-network provider, the NAP pays 70% of the maximum allowed amounts after your deductible (see "How Benefits Are Determined").

How Benefits Are Determined

Maximum Allowed Amount

Maximum allowed amount are those covered charges for services rendered by or on behalf of a non-network PHYSICIAN, for an amount not to exceed the amount determined by Anthem Blue Cross in accordance with the applicable fee schedule.

The maximum allowed amount charge is a charge which falls within the common range of fees billed by a majority of physicians for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

Covered Health Services

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

A Covered Health Service is a Medically Necessary health care service or supply described under "What the NAP Covers."

Covered Health Services must be provided:

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

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

Medically Necessary Services

Medically Necessary Services are those procedures, supplies, equipment or services which the Claims Administrator, Anthem Blue Cross on behalf of Anthem Blue Cross Life & Health, determines to be:

- Appropriate and necessary for the diagnosis or treatment of the medical condition;
- Provided for the diagnosis or direct care and treatment of the medical condition;
- Within standards of good medical practice within the organized medical community;
- Not primarily for your convenience, or for the convenience of your physician or another provider; and
- The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

  There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

  Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

  For HOSPITAL stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

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

Special Situations — Emergency Care and Treatment Away From Home

Emergency Care

If you or a covered family member experiences a medical emergency, seeking prompt care should be the first priority. Under the Plan, emergency care is provided 24 hours a day, 7 days a week, anywhere in the world.

A medical emergency is defined as a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that failure to get immediate medical care could be life-threatening or cause serious harm to bodily function.

Examples of medical emergencies include:

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

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

What to Do in Case of Emergency

In case of a medical emergency, go immediately to the nearest hospital emergency room. Call BlueCard at **1-800-810-2583** if you are admitted to the hospital. For emergency room visits, you pay a $35 copayment for each visit. The emergency room copayment does not apply to the annual deductible; however, it does count toward your annual out-of-pocket maximum. If hospitalization is required, your emergency room copayment will be waived; however, a hospital copayment of $100 will apply, then the deductible, if applicable.

It is important to understand that some conditions, such as colds, or symptoms, such as earaches, sprains and rashes, although potentially serious, may not require a visit to the emergency room. In these cases, you should always call your regular physician first.

Emergency room visits for non-emergencies (as determined by Anthem Blue Cross following federal law) at non-network hospitals will be covered at the non-network benefit level.

Treatment Away From Home

While Working Away From Home

If you have a work assignment outside of your home area — where there are no PPO NETWORK PROVIDERS — you will be covered at the higher level of benefits for non-routine medical care provided by any licensed physician, surgeon or general hospital. To receive network benefits, you should submit a letter with your first claim explaining the location and length of your assignment. Anthem Blue Cross will verify the assignment with PG&E. You will then be eligible to receive the higher level of network benefits for Covered Health Services.

While Traveling Away From Home

If you are traveling away from home within the United States, but where there are no PPO NETWORK PROVIDERS, and you need non-emergency medical services, you may be eligible to receive the higher level of network benefits by sending a written appeal to Anthem Blue Cross. See *Claims and Appeals Process for the Anthem NAP and Anthem CAP* for information on the appeals process.

If you are traveling out of the country, you may seek urgent or emergency care from any licensed provider. Non-emergency/non-URGENT CARE is not covered outside of the United States. Before leaving the U.S., you can call **1-800-810-2583** and a BlueCard coordinator can provide you with a list of Blue Cross Association participating hospitals in several international cities. You may also find this information at anthem.com. For inpatient care at a network BlueCard hospital, you pay only the applicable deductibles and copays. The provider files the claim for you.

For inpatient care at a non-network hospital, you will need to pay the hospital at the time you receive services and then submit a claim for reimbursement. To locate a claim form, go to anthem.com, then click Plan and then "Resources & Forms," to find the international claim form for Global core. To receive higher level network benefits, submit your claim form to Anthem Blue Cross with a letter explaining that the claim was incurred while traveling outside the country, along with a receipt for services, translated in English, if possible, which includes the following:

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

If you need treatment for a life-threatening emergency while traveling away from home, you should follow the steps under "Emergency Care."

Dependent Children Living Away From Home

Dependent children covered under the NAP who are residing away from home (for example, while attending school) will receive benefits in accordance with the provisions of the NAP. If your dependent children reside in an area where there are no PPO network providers or BlueCard providers — and they need non-emergency medical

services — they may be eligible to receive the higher level of network benefits by sending a written appeal to Anthem Blue Cross. See *Claims and Appeals Process for the Anthem NAP and Anthem CAP* for information on the appeals process.

If out-of-state, your Enrolled Dependents may access benefits with the BlueCard program, which enables members traveling or living outside their home state to access a broader network of doctors and hospitals at discounted rates through other Blue Cross/Blue Shield plans. To locate BlueCard providers, call **1-800-810-2583**. This number is also printed on the back of your ID card for handy reference.

What the NAP Covers

This topic lists covered services and supplies that are frequently used. If you have any questions on whether or not a specific service or supply is covered by the Plan, contact Anthem Blue Cross Member Services at **1-800-964-0530**.

For ease of reviewing, the NAP Covered Services are listed in alphabetical order, with the exception of "Other Covered Services and Supplies," which is listed last.

Acupuncture

Under the NAP, acupuncture services received from an M.D. or licensed acupuncturist who participates in the Anthem Blue Cross PPO network will be covered at 80% of the NEGOTIATED RATE, after deductible, for up to 20 visits per year. Acupuncture services received from a non-network acupuncturist will be covered at 70% of the maximum allowed amount (ELIGIBLE EXPENSES), after deductible, for up to 15 visits per year.

Ambulance Services

The following ambulance services are covered:

Emergency Only

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

Non-Emergency

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

Cancer Clinical Trials

Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials, if all the following conditions are met:

- The treatment provided in a clinical trial must either:

  Involve a *drug* that is exempt under federal regulations from a new drug application, or

  Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.
- You must be diagnosed with cancer to be eligible for participation in these clinical trials.
- Participation in such clinical trials must be recommended by your *physician* after determining participation has a meaningful potential to benefit the *member*.
- For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the *plan*, including health care services which are:

- Typically provided absent a clinical trial.
- Required solely for the provision of the investigational drug, item, device or service.
- Clinically appropriate monitoring of the investigational item or service.
- Prevention of complications arising from the provision of the investigational drug, item, device, or service.
- Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include the costs associated with any of the following:

- *Drugs* or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
- Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
- Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
- Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the *plan*.
- Health care services customarily provided by the research sponsors free of charge to *members* enrolled in the trial.

Note: You will be financially responsible for the costs associated with non-covered services.

Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to Independent Medical Review as described in Grievance Procedures.

- Coverage for routine mammographies (given as preventative measures to detect problems when a physician does not have a specific reason to suspect a medical problem), in accordance with Anthem Blue Cross' standard administrative policies. Diagnostic mammographies, which are given when there is a suspected problem, are covered as well.
- Coverage for mastectomies in accordance with the Women's Health and Cancer Rights Act, as described below. Notify Anthem Blue Cross five business days before receiving non-network services. By notifying Anthem Blue Cross, it can be verified whether a service is a reconstructive or a cosmetic procedure.

Cancer Resources

Anthem Cancer Case Management Program

- Anthem's case management program offers resources that specialize in oncology and is designed to help members understand what to expect and plan how to move forward with a cancer diagnosis. A nurse specially trained to support oncology patients will be available by phone to:
  - Answer your questions
  - Explain next steps
  - Connect you with resources to support you
  - Enroll you in outreach support from the American Cancer Society if you choose
- Are you currently undergoing treatment for cancer? If you have questions about benefits or resources, please contact Anthem for referral to a **case manager**: **1-888-613-1130**.

For details, visit the Anthem member pages at mypgebenefits.com > Physical Health > Medical - HAP Anthem.

Chiropractic Care

The NAP only covers chiropractic services that are deemed to be Covered Health Services. In addition, the NAP only covers services that are expected to result in a significant improvement in the patient's level of functioning. If a measurable increase in the patient's level of functioning does not occur as a direct result of the skilled chiropractic therapy intervention, then the treatment is considered maintenance in nature and is not covered. The measurable increase in the patient's level of functioning must be documented in treatment notes.

Under the NAP, for in-network California providers, the first five visits are covered without an American Specialty Health Network (ASHN) authorization. After the first five visits or for non-network providers, pre-approval for chiropractic care is required. The office visits to a chiropractor are covered at 80% of the NEGOTIATED RATE, after deductible, when visits are to a provider who participates in the Anthem Blue Cross PPO network and the care is pre-approved by ASHN. You can locate NETWORK PROVIDERS by calling Anthem Blue Cross directly or by visiting its website. To obtain pre-approval, call ASHN at **1-800-678-9133**. Non-network chiropractic care is covered at 70% of the maximum allowed amount (ELIGIBLE EXPENSES) and is limited to 15 visits per year.

You can locate chiropractic providers who participate in the Anthem Blue Cross PPO network by calling Anthem Blue Cross Member Services at **1-800-964-0530** or you may visit the Anthem Blue Cross website at anthem.com/ca/pge or anthem.com/ca. If there is not a network chiropractor within 30 road miles of your residence, you may seek care from a NON-NETWORK PROVIDER and receive network benefits. If this is the case, call Anthem Blue Cross Member Services before receiving services, to verify there are no network chiropractors within 30 miles and request the network level of benefit reimbursement.

Hearing Aids

The NAP covers 80% of the maximum allowed amount for Medically Necessary hearing aids and related expenses the plan will cover one hearing aid per ear every three years. The NAP also provides 80% in-network coverage and 70% of maximum allowable for non-network coverage for cochlear implants. The coverage is for adults and children (age 2 or older), for the following diagnoses: (1) severe to profound bilateral sensorineural hearing loss and severely deficient speech discrimination; or (2) post-lingual deafness in an adult.

Home Health Care and Hospice Care

Home health care and HOSPICE care under the NAP are covered at 90% of the NEGOTIATED RATE, after deductible, if you use an Anthem Blue Cross PPO NETWORK PROVIDER. Pre-authorization is required. A penalty of $300 applies if no pre-authorization is obtained.

Non-network home health care and hospice care is covered at 70% of the maximum allowed amount (ELIGIBLE EXPENSES) after deductible. The NAP will cover the services of an approved home health agency or hospice agency, provided the services are Medically Necessary Covered Health Services, not custodial in nature, ordered by your attending PHYSICIAN (whether network or non-network), and rendered under a written treatment plan approved by Anthem Blue Cross. Custodial care, which is not covered, is defined as care provided primarily to assist an individual in meeting the activities of daily living including, but not limited to, walking, bathing, dressing, eating, preparation of special diets, changing catheters, and supervision over self-administration of medications not requiring constant attention of trained medical personnel. It is care that can be taught to a lay person who does not have any professional qualifications, skills or training.

Full-time nursing care in the home and homemaker services and supplies (including meals delivered to your home) are also not covered. When your doctor recommends either home health or hospice care, he or she must contact Anthem Blue Cross at **1-800-274-7767** for pre-authorization.

Services in Your Home

The Plan covers the following services when rendered in the patient's home, provided that the services are Medically Necessary Covered Health Services and are not considered custodial care, as determined by Anthem Blue Cross:

- Nursing services provided by a registered nurse (R.N.), or a licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.) when under the supervision of an R.N.
- Services of a home health aide.
- Physical, occupational, speech or respiratory therapy; medical social services; and nutritional counseling.

- For a patient formally admitted to a hospice program: homemaking services; counseling for the patient and covered family members; up to three days of respite care during a six-month period; and bereavement counseling by a certified social worker who is an employee of the hospice, for up to 12 months after the patient's death. Bereavement counseling benefits are limited to $25 per visit, four visits per family. Counseling may also be covered by Carelon Behavioral Health; see *Mental Health and Substance Use Disorder Coverage for LTD Plans*.

Hospice Facility

Medically Necessary Covered Health Services in a hospice facility are covered when a patient in the latter stages of a terminal illness is formally admitted to an inpatient hospice program and Medical Management has approved the admission.

The following inpatient hospice services are covered:

- Bed, board and general nursing care.
- Medical care provided by other professional providers employed by the facility.
- Hospice facility services and supplies.
- Family counseling related to the patient's illness. Counseling may also be covered by Carelon Behavioral Health; see *Mental Health and Substance Use Disorder Coverage for LTD Plans*.
- Bereavement counseling for the family after the patient's death. Counseling may also be covered by Carelon Behavioral Health; see *Mental Health and Substance Use Disorder Coverage for LTD Plans*.

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

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

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

Hospital Care — Inpatient

Inpatient HOSPITAL care is covered at 100% after a $100 copayment and after meeting the annual deductible, when you use a participating PPO NETWORK PROVIDER. Non-network inpatient hospital care is covered at 70% of ELIGIBLE EXPENSES after meeting the deductible. For non-emergency inpatient hospital care, pre-authorization is required. A penalty of $300 applies if no pre-authorization is obtained. When services are performed by a network provider, your provider will contact Anthem Blue Cross Medical Management for pre-authorization. When services are performed by a NON-NETWORK PROVIDER, it is your responsibility to contact Anthem Blue Cross Medical Management for pre-authorization or make sure your provider has obtained the necessary pre-authorization. The hospital copayment does not apply to the annual deductible.

Covered inpatient hospital services include:

- Room and board in semi-private accommodations; private room if a Medically Necessary Covered Health Service (as determined by standards set by Anthem Blue Cross — see "Covered Health Services" under "How Benefits Are Determined").
- SPECIAL CARE UNITS.
- Medical and surgical supplies.
- General nursing care.
- Use of operating and special treatment rooms.
- Anesthesia and its administration by a salaried hospital employee.
- Administration of blood and blood plasma, including the cost of unreplaced blood, blood products and blood processing.
- Hospital ancillary services, including laboratory, cardiology, pathology, radiology and any professional components for such services.
- Routine nursery care for a newborn if the child is enrolled in the NAP.

- Drugs, medicines and oxygen supplied by and used in the hospital.
- Pre-admission testing performed within seven days before hospital admission or outpatient surgery.
- Radiation therapy, chemotherapy, physical therapy, respiratory therapy, and hemodialysis treatment.
- Short-term speech therapy for correction of speech impairments resulting from illness, injury, surgery, or previous therapeutic processes. Speech therapy due to functional nervous disorders is not covered.
- Physical therapy when furnished by the hospital as a regular service.
- Occupational therapy when furnished by the hospital in conjunction with physical therapy treatments.
- Dental care when a hospital admission is required for dental surgery or extraction of teeth, general anesthesia is required, and a PHYSICIAN certifies that the hospitalization is Medically Necessary. Any other service related to the dental procedure, such as the dentist's services, is not covered.

Childbirth

Under federal law, the duration of benefits provided for any hospital STAY in connection with childbirth for a mother or newborn child may not be restricted to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section. However, this 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 baby earlier than 48 hours (or 96 hours, as applicable).

Hospital Care — Outpatient

Covered outpatient HOSPITAL services include:

- Outpatient surgical services. This includes Medically Necessary Covered Health Services rendered in a freestanding AMBULATORY SURGICAL CENTER, a short-STAY surgical unit or an outpatient department of a hospital.
- Emergency hospital outpatient services for the first visit for emergency care and treatment of a sudden and unforeseeable illness or injury which, if not immediately diagnosed and treated, could be life-threatening or cause serious harm to bodily function.
- Medically Necessary Outpatient Covered Health Services for radiation therapy, chemotherapy and hemodialysis treatment.

Organ and Tissue Transplants

Organ and tissue transplants are covered at 100% of the NEGOTIATED RATE, after deductible, when pre-authorized by Anthem Blue Cross and performed at an Anthem Blue Cross Center of Medical Excellence (CME) facility. If members use a facility that participates in the Anthem Blue Cross PPO network, but which is not a CME, organ and tissue transplant services are covered at 70% of the negotiated rate, after deductible. Pre-authorization is required for all transplant services.

Benefits are available for the following organ and tissue transplants when the transplant is ordered by a PHYSICIAN, meets the definition of a Covered Health Service and is not an unproven, experimental, or investigational service, as described under "What the NAP Doesn't Cover."

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

- Pancreas transplants
- Small bowel transplants
- Cornea transplants

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

Bone Marrow Donor Search

Pre-authorization is required for bone marrow donor search services. Bone marrow donor search services are covered at 100% after deductible, when you use network providers at a CME or at 70% at an in-network facility that is not a CME. This search is only necessary when a family donor is not found. The maximum benefit per search is $30,000. Bone marrow donor search services are not covered out of network.

In California, Anthem Blue Cross has established a Centers of Medical Excellence (CME) network of transplant facilities to provide services for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures). Equivalent approved transplant facilities are located outside of California.

CMEs are health care providers designated by Anthem Blue Cross as selected facilities for specified medical services. A provider participating in a CME network has a CME Agreement in effect with Anthem Blue Cross at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. CMEs agree to accept the CME negotiated rate as payment in full for covered services. A participating provider in the Anthem Blue Cross PPO network is not necessarily a CME. A provider's participation in the Anthem Blue Cross PPO network or other agreement with Anthem Blue Cross is not a substitute for a CME Agreement.

Obtain Authorization from Anthem Blue Cross' Authorization Program

Authorization is required for all transplant services. You must call **Pre-Authorization and Pre-Service** at **1-800-274-7767** as soon as the possibility of a transplant arises. The Authorization Program will arrange for a pre-transplantation evaluation to be performed at a CME transplant facility. The Authorization Program also can discuss your benefit options and any special transplant guidelines.

Travel Expenses

You may be eligible to receive reimbursement for some or all of your travel expenses associated with undergoing an organ transplant. For more information, see "Transportation and Lodging."

Prescription Drugs

Inpatient Prescription Drugs

Prescription drugs you receive while you are hospitalized, or "inpatient" drugs, are covered by your Anthem Blue Cross medical plan. If you are hospitalized in a PPO network HOSPITAL, prescription drugs are covered at 100%. If you are hospitalized in a non-network hospital, prescription drugs are covered at 70%.

Outpatient Prescription Drugs

Prescriptions dispensed and filled on an outpatient basis are covered by Express Scripts, as described in the section entitled *Prescription Drug Coverage for the NAP and CAP*. Outpatient drugs are not covered by the medical provisions of the Plan administered by Anthem Blue Cross, unless dispensed as an infusion drug or injection that requires the expertise of trained medical personnel.

Professional Services

The following professional services are covered, if deemed to be Medically Necessary Covered Health Services as determined by Anthem Blue Cross:

- Services of a PHYSICIAN, surgeon or assistant surgeon
- Services of an anesthetist or anesthesiologist in connection with surgery

- Services of a consulting physician when requested by your doctor
- Constant care services rendered by a physician when you are in critical condition
- Physician visits to a HOSPITAL or SKILLED NURSING FACILITY during a covered inpatient confinement
- Visits to your doctor's office or physician house calls for treatment of illness, disease or injury
- Radiation therapy
- Outpatient diagnostic X-rays and lab exams
- Injections, inoculations and immunizations
- Physician services in the outpatient department of a hospital, ambulatory surgical facility or short-STAY surgical unit
- Routine physical exams
- Routine or diagnostic Pap smears and mammograms (covered by X-ray and lab benefit)
- Well-baby care
- Services of a licensed physical therapist for a covered inpatient hospital or skilled nursing facility confinement

Mental Health Care and Substance Use Disorder Treatment

Only detoxification that is considered to be medical care and that is deemed to be a Medically Necessary Covered Health Service is covered by the medical portion of the Plan administered by Anthem Blue Cross. Mental health care and substance use disorder treatment are covered under the separate Mental Health and Substance Use Disorder provisions of the Plan, administered by Carelon Behavioral Health.

Skilled Nursing Facility

SKILLED NURSING FACILITY services under the NAP are covered at 90% of the NEGOTIATED RATE, after deductible, when you use an Anthem Blue Cross PPO NETWORK PROVIDER. Non-network skilled nursing facility services are covered at 70% of the maximum allowed amount (ELIGIBLE EXPENSES) after the deductible. A HOSPITAL STAY of at least three consecutive days for the same condition is required prior to admission to a skilled nursing facility, and the admission to the skilled nursing facility must be within 30 days of your discharge from the hospital. Pre-authorization is also required. A penalty of $300 applies if no pre-authorization is obtained. Remember, either you or your doctor must contact Anthem Blue Cross for pre-authorization (see "Medical Management Programs Under the NAP and CAP") and meet all the stated criteria for coverage.

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

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

Transportation and Lodging

- The Authorization Program will assist the patient and family with travel and lodging arrangements associated with transplant procedures, bariatric surgery or gender-affirming surgery. Expenses for travel and lodging are based on IRS guidelines and include the following: patient and companion transportation, such as airfare, train, or bus fares; hotel or apartment rentals; gas and car rentals; and taxes on covered expenses.
- Meals do not qualify for reimbursement, per IRS regulations.

For Organ Transplants

- Travel and lodging expenses are available for transplant patients only if the transplant recipient resides more than 75 miles from the Center of Medical Excellence (CME) facility or a pre-authorized participating kidney or cornea transplant facility.

- Transplant travel expense for a pre-authorized, specified transplant, including for purposes of evaluation prior to the transplant and post-discharge follow-up.
- If the transplant patient is a covered dependent minor child, the transportation expenses of up to two companions will be covered.
- There is a combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.

For Bariatric or Gender-Affirming Surgery

- Travel and lodging expenses are available for bariatric or gender-affirming surgery patients only if the patient resides more than 50 miles from the Center of Medical Excellence (CME) facility or a pre-authorized participating facility performing the surgery.
- There is a combined overall lifetime maximum of $3,000 per covered person for all transportation and lodging expenses incurred by the patient and companion(s) and reimbursed under this Plan in connection with bariatric or gender-affirming procedures.

Other Covered Services and Supplies

Other covered services and supplies include:

- Outpatient professional nursing services of a registered nurse (R.N.), licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.) that are certified as Medically Necessary Covered Health Services by your PHYSICIAN.
- Services of a licensed midwife working under the direction of a physician. Does not include services of a lay midwife or a doula.
- Medically Necessary Covered Health Services of a licensed physical or occupational therapist, when provided by someone other than a close relative or someone who resides in your home, when ordered by a participating physician, and when judged by the physician to be subject to significant improvement through such therapy. The therapy must be expected to result in significant, objective, measurable physical improvement in the covered person's condition within two months of the start of the treatment. Services may be reviewed for medical necessity and must be deemed medically necessary to be covered. After 24 visits in a calendar year, pre-authorization is required. Both physical therapy and occupational therapy visits will be counted on a combined basis when calculating the first 24 visits each calendar year.
- Non-experimental inpatient drugs and medicines which are approved by the Food and Drug Administration (FDA).
- Non-human and artificial limbs or eyes, when determined to be a Medically Necessary Covered Health Service.
- Rental or purchase of durable medical equipment (including prosthetic and orthotic devices, except foot orthotics, which are excluded from coverage) that is ordered by a physician, approved by Anthem Blue Cross, determined by Anthem Blue Cross to be a Medically Necessary Covered Health Service, and is to be used solely by the patient. Pre-authorization is required for the purchase or cumulative rental of durable medical equipment for which the total price is equal to or greater than $1,000; there will be a $300 penalty if pre-authorization is not obtained. If an item is rented, the rental price for the entire rental period cannot be more than the purchase price. The rented item must be returned if the member switches plans. Necessary repairs and maintenance of purchased equipment are also covered if not provided under a manufacturer's warranty or purchase agreement.
- Wigs and toupees for alopecia areata or alopecia resulting from chemotherapy or radiation therapy; limit of one wig or toupee every two years.
- Initial pair of eyeglasses or contact lenses prescribed by a doctor after eye surgery; eyeglasses or lenses when needed to replace loss of the natural lens.

- Rental of dialysis equipment and all Medically Necessary Covered Health Services and supplies required for hemodialysis treatment.
- Oxygen, including its administration.
- Short-term speech therapy services rendered by a certified speech therapist when required due to surgery, illness, injury, or previous therapeutic processes, when ordered by a participating physician, and when judged by the physician to be subject to significant improvement through such therapy. Speech therapy due to functional nervous disorders is not covered; see "Exclusions" later in this section. The therapy must be expected to result in significant, objective, measurable improvement in the covered person's condition within two months of the start of the treatment. Services may be reviewed for medical necessity and must be deemed medically necessary to be covered. After 24 visits in a calendar year, pre-authorization is required for additional visits in the same calendar year.
- Mental health and substance use disorder treatment benefits are covered under the Plan, but these benefits are available through the Mental Health/Substance Use Disorder provisions of the Plan administered by Carelon Behavioral Health, rather than Anthem Blue Cross. See *Mental Health and Substance Use Disorder Coverage for LTD Plans* for more information.
- Applied Behavioral Analysis (ABA) is covered under the Plan, but these benefits are available through the Mental Health provisions of the plan administered by Carelon Behavioral Health. See *Mental Health and Substance Use Disorder Coverage for LTD Plans* for more information.
- Diabetes self-management education programs.
- Surgery to change an individual's appearance when the purpose is:

  to correct the result of an ACCIDENTAL INJURY; or

  to treat a condition, including a birth defect, that impairs the function of a body organ.
- Diagnostic procedures for the prenatal diagnosis of genetic disorders of the fetus when authorized by a participating physician in the case of high-risk pregnancy.
- Surgical treatment of morbid obesity when authorized by a participating physician and approved by Anthem Blue Cross, when surgical treatment of morbid obesity is necessary to treat another life-threatening condition involving morbid obesity, and when it has been documented that non-surgical treatments of the morbid obesity have failed. Travel expense benefit of up to $3,000 is also available if certain criteria is met in connection with bariatric surgery (see "Transportation and Lodging").
- INFERTILITY treatments, up to a lifetime maximum of $7,000 combined for all plans administered by Anthem Blue Cross or prior claims administrators. The benefit includes, but is not limited to, in vitro fertilization services, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and microinjection techniques. Services provided must be considered safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications.
- Gender-affirming surgery, if the surgery meets all the criteria for being deemed Medically Necessary by Anthem Blue Cross. Travel expense benefit of up to $3,000 is also available if certain criteria is met in connection with gender-affirming surgery (see "Transportation and Lodging").

Anthem Comprehensive Access Plan (CAP) (Available only to employees on Long-Term Disability)

Eligibility for the Anthem Comprehensive Access Plan (CAP) is dependent upon your Medicare-eligibility status and/or where you live. The plan is only available to employees on Long-Term Disability (LTD) and their eligible dependents.

If you live in an area that is not covered by the Network Access Plan (NAP), or if you or a dependent is Medicare-eligible, you are eligible for the LTD Comprehensive Access Plan (CAP). The CAP is a fee-for-service plan administered by Anthem Blue Cross on behalf of Anthem Blue

Important Information

For additional important information about the Anthem Blue Cross-administered CAP, see *Glossary for LTD Plans* and *Claims and Appeals Process for the Anthem NAP and Anthem CAP*.

Cross Life & Health Insurance Company (Anthem Blue Cross Life & Health). The Claims Administrator is referred to as "Anthem Blue Cross" in this document.

CAP at a Glance

This is a summary of the CAP benefits. Please refer to "What the CAP Covers" for more information on covered services and exclusions.

The information in this chart is intended to be a summary of benefits provided by the CAP as of January 1, 2026. The information contained in the applicable service provider contract between The Pacific Gas and Electric Company and Anthem Blue Cross shall govern in case of conflict between this chart and the service provider contract. Please refer to the most recent information about your medical plan benefit options, which are updated annually in the Open Enrollment materials.

General	May use provider of choice (may experience savings with Anthem PPO NETWORK PROVIDERS). Annual deductible: ▪ $120/person; $240/two people; $320/three or more people Annual out-of-pocket maximum (includes deductible): ▪ $750/person; no more than $1,500/family No lifetime maximum. No pre-existing condition exclusions. All plan benefits and out-of-pocket maximums are based on ELIGIBLE EXPENSES only. ▪ For the definition of "Eligible Expenses," see the *Glossary* section.
Hospital Stay	100% after a $100 copayment; pre-authorization required for non-emergency care, $300 penalty if not obtained; covers semi-private room (private if Medically Necessary); includes intensive care.
Skilled Nursing Facility (For more information on custodial care, see under "What the CAP Covers")	90% for semi-private room after 3 days in HOSPITAL; pre-authorization required, $300 penalty if not obtained. Excludes custodial care.
Emergency Room	$35 copay/visit for medical emergencies; waived if admitted. Lab/X-ray covered separately.
Outpatient Hospital care	$35 copay/visit for outpatient surgery; waived if admitted. Lab/X-ray covered separately
Maternity Care	Covered as any other condition. Pre-authorization required for delivery stays beyond 48 hours for normal delivery (96 hours for cesarean section); $300 penalty if not obtained.
Well-Baby Care	Covered as any other condition.
Office Visits	▪ Primary care $10 copay/visit ▪ Specialist (including OB/GYN) – $20 copay/visit ▪ Lab/X-ray covered separately

Telemedicine	*LiveHealth Online* is a telemedicine service that allows PG&E employees to engage in a "virtual office visit" with a board-certified doctor, psychiatrist, or licensed therapist via a live video/audio conference in a HIPAA-secure environment. You can use *LiveHealth Online* anywhere and anytime. Although not covered by the CAP, the cost of a visit is nominal when compared to an in-person visit. Visit mypgebenefits.com > Physical Health > Medical – HAP Anthem to see the current cost. ▪ LHO Primary care - $10 copay/visit ▪ LHO Specialist - $20 copay/visit All you have to do to get started is register. *LiveHealth Online* can be accessed 24/7 from any computer or mobile device that has a high-speed Internet connection and a webcam. It's like a virtual office that you can use when you're sick, experiencing something minor like a rash, you need help with anxiety or depression, or when you need a prescription. ▪ To access *LiveHealth Online* via your personal computer, register at LiveHealthOnline.com, or download the app to get started on a mobile device. For additional information about Anthem's telemedicine program, please refer to the LiveHealth Online FAQs, email **customersupport@livehealthonline.com**, or call **1-855-603-7985.**
Urgent Care Visits	▪ Primary care $10 copay/visit ▪ Specialist (including OB/GYN) – $20 copay/visit ▪ Lab/X-ray covered separately
Routine Physical Examinations	▪ Primary care – $10 copay/visit ▪ Specialist (including OB/GYN) – $20 copay/visit ▪ Lab/X-ray covered separately
Immunizations and Injections	95%
Routine Eye Examinations	Not covered.
X-rays and Lab Tests	90%
Pre-Admission Testing	95%
Home Health Care and Home Hospice Care	90%; requires prior authorization; $300 penalty if not obtained. Excludes custodial care[1]
Outpatient Physical Therapy	80%

Outpatient Prescription Drugs	Covered by separate drug plan administered by Express Scripts. See *Prescription Drug Coverage for the NAP and CAP* for details.
Inpatient and Outpatient Mental Health Care	Covered by separate Mental Health Program administered by Carelon Behavioral Health. See the *Mental Health and Substance Use Disorder* subsection.
Inpatient and Outpatient Substance Use Disorder Care	Covered by separate Substance Use Disorder Program administered by Carelon Behavioral Health. See the *Mental Health and Substance Use Disorder* subsection.
Durable Medical Equipment	80%; pre-authorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained.
Hearing Aids and Cochlear Implants	▪ 80% for hearing aids and exams to determine the need for hearing aids or the need to adjust them. ▪ 80% for cochlear implants for adults and children (age 2 or older), for the following diagnoses: (1) severe to profound bilateral sensorineural hearing loss and severely deficient speech discrimination; or (2) post-lingual deafness in an adult. Hearing aid hardware is limited to one hearing aid per ear every three years,
Chiropractic Care	80% for Medically Necessary care only; pre-authorization by American Specialty Health Network (ASHN) required after initial visit.
Acupuncture	80% for up to 20 visits per year from licensed acupuncturist or M.D.
Services Received Outside of the U.S.	Limited to urgent/emergency services only.
Other Benefits	INFERTILITY Treatment—Paid according to type of benefit; $7,000 lifetime maximum. Balances from prior plans carry forward. Transplant Services—100% when performed at a Center of Medical Excellence (CME) or approved facility only; pre-authorization required for all transplant services.

1 For more information on "custodial care," see "What the CAP Covers."

How the CAP Works

The CAP is a fee-for-service plan that provides coverage worldwide (coverage limited outside of United States; see below), so care may be received from any PHYSICIAN or HOSPITAL of your choice. Participants of the CAP are not required to go to an Anthem PPO NETWORK PROVIDER to receive the highest level of Plan benefits(*see exceptions below) and are not required to choose a primary care physician.

*Bariatric surgery, transplants and LHO services must be provided by in-network provider.

In California, Plan members who are not eligible for Medicare can use the Anthem Blue Cross Prudent Buyer PPO network if they wish. However, non-Medicare-eligible members who choose to use network providers will benefit by having coinsurance based on the NEGOTIATED RATE, being assured that they will not be balance billed, and being alleviated of the burden of paying up front, since network providers must bill Anthem Blue Cross first. However, there is no penalty for not using a network provider. Members who are eligible for Medicare can maximize their benefits by using providers who accept Medicare.

Outside of California, Plan members who are not eligible for Medicare may use the BlueCard PPO network if they wish. These are providers located across the country who have agreed to provide services at negotiated rates. However, there is no penalty for not using BlueCard network providers. These providers participate in one of the

local Anthem Blue Cross Blue Shield plan PPO networks and are available to you through the BlueCard Program, although they do not contract directly with Anthem Blue Cross. Also available are traditional providers who might not participate in a BlueCard PPO network, but who have agreed to provide PPO members with health care services at a discounted rate. To locate BlueCard PPO providers, you may call Anthem Blue Cross Member Services at **1-800-964-0530** or you can visit Anthem Blue Cross' website at anthem.com.

Outside of the United States, only emergency/URGENT CARE is covered.

Please remember, you have a responsibility to work together with the physician(s) you select to ensure that all your medical needs are appropriately met, and to notify Anthem's Medical Management program when pre-authorization is required. (See "Medical Management Programs Under the NAP and CAP" for more information.)

Continuity of Care

You may have to find a new Provider or health care facility when:

- the Plan's network changes and the Provider or facility you have is not in the new network; or
- you are already enrolled in the Plan and your Provider or facility stops participating in the Plan's network.

However, in some cases, you may be able to keep going to your current Provider or facility to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. A continuing care patient is an individual who is undergoing treatment for one of the following:

- a serious and complex condition;
- institutional or inpatient care;
- pregnancy;
- terminal illness; or
- a scheduled non-elective surgery.

Routine procedures, minor illnesses, and elective surgical procedures generally are not covered under this continuity of care provision.

If you qualify as a continuing care patient, the Plan will notify you, and you will be given the opportunity to submit a request for continuity of care. If your request is approved, you will generally be entitled to continue your care, subject to the same terms and conditions that applied when your Provider or facility was in the Plan's network, until the earlier of: (1) the end of a 90-day period that begins on the date you receive notice that you qualify as a continuing care patient, or (2) the date on which you are no longer a continuing care patient with respect to that Provider or facility.

Deductibles and Maximums

Deductibles

The annual deductible is $120 for one person, $240 for two people and $320 for three or more people.

Charges for non-covered services, penalties for not obtaining authorization, amounts over the maximum allowed amount, and flat dollar copayments (for example, for doctor's office visits, emergency room visits, or HOSPITAL admissions) do not apply toward the annual deductible.

Examples of How Copayments Work With the Annual Deductible (for non-Medicare-eligible participant)

The following examples show how copayments affect a non-Medicare-eligible participant's annual deductibles for three office visits — all three at NETWORK PROVIDERS.

Visit #1 to a Primary Care Physician: Provider charges $100 for the office visit. The claim would be paid as follows:	**Network Provider**
Total Billed	$100

Visit #1 to a Primary Care Physician: Provider charges $100 for the office visit. The claim would be paid as follows:	Network Provider
Amount Allowed for a PPO network participating provider (based on the negotiated discount)	$75
PCP Office Visit Copay	$10
Amount Applied to Calendar Year Deductible	$65
Calendar Year Deductible Remaining To be Met	$55
Amount Paid by the Plan	$0
Total Member Responsibility for this Visit	$75

Visit #2 to an OB/GYN Specialist: Provider charges $150 for the office visit. The claim would be paid as follows:	Network Provider
Total Billed	$150
Amount Allowed for a PPO network participating provider (based on the negotiated discount)	$100
Specialist Office Visit Copay	$20
Allowed Amount Remaining After Copay	$80
Amount Applied to Remaining Calendar Year Deductible which is Now Met	$55
Amount Paid by the Plan	$25
Total Member Responsibility for this Visit	$75

Visit #3 to a Dermatology Specialist: Provider charges $165 for the office visit. The claim would be paid as follows:	Network Provider
Total Billed	$165
Amount Allowed for a PPO network participating provider (based on the negotiated discount)	$125
Specialist Office Visit Copay	$20
Allowed Amount Remaining After Copay	$105
Amount Paid by the Plan	$105
Total Member Responsibility for this Visit	$20

Plan Maximums

Out-of-Pocket Maximum

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

The annual out-of-pocket maximum is $750 per individual and $1,500 per family.

Charges for non-covered services, charges above the maximum allowed amounts (ELIGIBLE EXPENSES), and penalties for not obtaining pre-authorization do not apply toward the annual out-of-pocket maximum.

Lifetime Maximums

The Plan does not have an overall lifetime maximum benefit, but there are lifetime maximums for the following services or supplies:

Service or Supply	Lifetime Maximum
INFERTILITY Treatments	$7,000 combined for all PG&E self-insured medical plans administered by Anthem Blue Cross or prior claims administrators.
Reimbursement for Travel and Lodging Expenses in connection with Organ Transplants Transportation and lodging expenses for the transplant recipient and companion(s)	$10,000 combined for all travel expenses (IRS limit).
Reimbursement for Travel and Lodging Expenses incurred in connection with Bariatric/Gender-Affirming Surgery	$3,000 combined for all travel expenses.

Copayments and Benefit Percentages

The plan's coinsurance (percentage coverage) does not begin until after the annual deductible has been met. All copayments apply before the annual deductible. The coinsurance and copays are listed in the Summary of CAP Benefits. The basis on which Eligible Expenses are calculated depends on your Medicare status and/or whether or not you use network providers, as described below.

Non-Medicare Family Members

Eligible Expenses will be reimbursed based on NEGOTIATED RATES for NETWORK PROVIDERS and the maximum allowed amount for NON-NETWORK PROVIDERS, after any copayments and after meeting the annual deductible. If your non-network provider bills an amount above the maximum allowed amount (Eligible Expenses), you will be responsible for paying this difference along with your coinsurance. Network providers have agreed not to charge you more than the negotiated rate, so you will not be responsible for any amount in excess of the negotiated rate for Covered Health Services when you use a network provider.

Medicare Family Members

If you or any of your covered dependent(s) are eligible for Medicare, the CAP will provide secondary coverage after Medicare, and Eligible Expenses will be based on Medicare's "Allowed Amount," See "How the CAP Integrates with Medicare: Two Examples" for more information .

Copayment for Emergency Room and Outpatient Surgery

The CAP provides coverage for outpatient HOSPITAL services including outpatient surgery, radiation therapy, chemotherapy and hemodialysis. For outpatient hospital emergency room visits and outpatient surgery, you must pay a $35 copayment for each visit. Your $35 copayment will not be applied to your deductible; however, it will count toward your annual out-of-pocket maximum. Please note that any outpatient lab work and/or X-rays you receive are covered separately after the deductible at 90%.

Please refer to "Emergency Care" for more information on emergency care.

Physician Office Visit Copayment

Benefits are provided for primary care PHYSICIAN office visits for illness or disease after you pay a $10 copayment per visit. The copayment for a specialist visit is $20. The office visit copayment does not apply to the annual deductible; however, it will count toward your annual out-of-pocket maximum.

How Benefits Are Determined

Maximum Allowed Amount

Maximum Allowed Amount are those covered charges for services rendered by or on behalf of a non-network PHYSICIAN, for an amount not to exceed the amount determined by Anthem Blue Cross in accordance with the applicable fee schedule.

The maximum allowed amount is a charge which falls within the common range of fees billed by a majority of physicians for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

Covered Health Services

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

A Covered Health Service is a Medically Necessary health care service or supply described under "What the CAP Covers" and which is not excluded under "What the Anthem NAP and Anthem CAP Don't Cover," including experimental or investigational services or unproven services.

Covered Health Services must be provided:

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

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

Medically Necessary Services

Medically Necessary Services are those procedures, supplies, equipment or services which the Claims Administrator, Anthem Blue Cross on behalf of Anthem Blue Cross Life & Health, determines to be:

- Appropriate and necessary for the diagnosis or treatment of the medical condition;
- Provided for the diagnosis or direct care and treatment of the medical condition;
- Within standards of good medical practice within the organized medical community;
- Not primarily for your convenience, or for the convenience of your physician or another provider; and
- The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

  There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

  Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

  For HOSPITAL stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

The fact that a physician, licensed professional or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary, even though it is not specifically listed as an exclusion or limitation. The services or supplies must be ordered by the attending physician or licensed

professional for the direct care and treatment of a covered illness, injury or condition. Services must be standard medical practice where received for the illness, injury or condition being treated and must be legal in the United States.

Emergency Care

If you or a covered family member experiences a medical emergency, seeking prompt care should be the first priority. Under the Plan, emergency care is provided 24 hours a day, 7 days a week, anywhere in the world.

A medical emergency is defined as a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that failure to get immediate medical care could be life-threatening or cause serious harm to bodily function.

Examples of medical emergencies include:

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

If the Anthem CAP is your primary medical coverage (i.e., you are not eligible for Medicare), you or your representative must notify Anthem Blue Cross within one working day of an emergency hospital admission or procedure, unless extraordinary circumstances prevent such notification within that time period.

What to Do In Case of Emergency

In case of a medical emergency, you should go immediately to the nearest hospital emergency room. For emergency room visits, you pay a $35 copayment for each visit. The emergency room copayment does not apply to the annual deductible; however, it does count toward your annual out-of-pocket maximum and then the deductible applies, if applicable. If hospitalization is required, your emergency room copayment will be waived; however, a hospital copayment of $100 will apply.

It is important to understand that some conditions, such as colds, or symptoms, such as earaches, sprains and rashes, although potentially serious, may not require a visit to the emergency room. In these cases, you should always call your regular physician first.

What the CAP Covers

This topic lists covered services and supplies that are frequently used. If you have any questions on whether or not a specific service or supply is covered by the Plan, contact Anthem Blue Cross Member Services at **1-800-964-0530**.

For ease of reviewing, the CAP Covered Services are listed in alphabetical order, with the exception of "Other Covered Services and Supplies," which is listed last.

Acupuncture

Under the CAP, acupuncture services received from an M.D. or licensed acupuncturist who participates in the Anthem Blue Cross PPO network will be covered at 80% of the NEGOTIATED RATE, after the deductible. You may

receive coverage for up to 20 acupuncture visits per year. Acupuncture services received from a non-network acupuncturist will be covered at 80% of the maximum allowed amount (ELIGIBLE EXPENSES), after the deductible.

Ambulance Services

The following ambulance services are covered:

Emergency Only

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

Non-Emergency

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

Cancer Clinical Trials

Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials, if all the following conditions are met:

- The treatment provided in a clinical trial must either:
  - Involve a drug that is exempt under federal regulations from a new drug application, or
  - Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.
- You must be diagnosed with cancer to be eligible for participation in these clinical trials.
- Participation in such clinical trials must be recommended by your *physician* after determining participation has a meaningful potential to benefit the *member*.
- For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the *plan*, including health care services which are:

- Typically provided absent a clinical trial.
- Required solely for the provision of the investigational drug, item, device or service.
- Clinically appropriate monitoring of the investigational item or service.
- Prevention of complications arising from the provision of the investigational drug, item, device, or service.
- Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include the costs associated with any of the following:

- Drugs or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
- Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
- Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
- Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the *plan*.

- Health care services customarily provided by the research sponsors free of charge to *members* enrolled in the trial.

Note: You will be financially responsible for the costs associated with non-covered services.

Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to Independent Medical Review as described in Grievance Procedures.

- Coverage for routine mammographies (given as preventative measures to detect problems when a physician does not have a specific reason to suspect a medical problem), in accordance with Anthem Blue Cross' standard administrative policies. Diagnostic mammographies, which are given when there is a suspected problem, are also covered.
- Coverage for mastectomies in accordance with the Women's Health and Cancer Rights Act, as described below. Notify Anthem Blue Cross five business days before receiving services. By notifying Anthem Blue Cross, it can be verified whether a service is a reconstructive procedure or a cosmetic one.

Cancer Resources

- Anthem Cancer Case Management Program
- Anthem's case management program offers resources that specialize in oncology, and is designed to help members understand what to expect and plan how to move forward with a cancer diagnosis. A nurse specially trained to support oncology patients will be available by phone to:
  - Answer your questions
  - Explain next steps
  - Connect you with resources to support you
  - Enroll you in outreach support from the American Cancer Society if you choose
- Are you currently undergoing treatment for cancer? If you have questions about benefits or resources, please contact Anthem for referral to a **case manager**: **1-888-613-1130**.

For details, visit the Anthem member pages at mypgebenefits.com > Physical Health.

Chiropractic Care

The CAP only covers chiropractic services that are deemed to be Covered Health Services. In addition, the CAP only covers services that are expected to result in a significant improvement in the patient's level of functioning. If a measurable increase in the patient's level of functioning does not occur as a direct result of the skilled chiropractic therapy intervention, then the treatment is considered maintenance in nature and is not covered. The measurable increase in the patient's level of functioning must be documented in treatment notes.

Under the CAP, pre-approval for chiropractic care is required after the 5th visit. The office visits to a chiropractor are covered at 80% of the NEGOTIATED RATE or maximum allowed amount, after deductible, when visits are pre-approved by American Specialty Health Network (ASHN). You can locate NETWORK PROVIDERS by calling Anthem Blue Cross directly or by visiting its website. To obtain approval, call ASHN at **1-800-678-9133**.

Hearing Aids

The CAP covers 80% of the maximum allowed amount, subject to deductible, for Medically Necessary hearing aids and related expenses. The plan will cover one hearing aid per ear every three years. The CAP also pays 80% after deductible for cochlear implants for adults and children (age two or older), for the following diagnoses: (1) severe to profound bilateral sensorineural hearing loss and severely deficient speech discrimination; or (2) post-lingual deafness in an adult.

Home Health Care and Hospice Care

Home health care and HOSPICE care under the CAP are covered at 90% of the NEGOTIATED RATE, after deductible, if you use an Anthem Blue Cross PPO NETWORK PROVIDER. Non-network home health care and hospice care is covered

at 90% of the maximum allowed amount (ELIGIBLE EXPENSES) after deductible. Pre-authorization is required, and a penalty of $300 applies if no pre-authorization is obtained.

The CAP will cover the services of an approved home health agency or hospice agency, provided the services are Medically Necessary Covered Health Services, not custodial in nature, ordered by your attending PHYSICIAN and rendered under a written treatment plan approved by Anthem Blue Cross. Custodial care, which is not covered, is defined as care provided primarily to assist an individual in meeting the activities of daily living including, but not limited to, walking, bathing, dressing, eating, preparation of special diets, changing catheters, and supervision over self-administration of medications not requiring constant attention of trained medical personnel. It is care that can be taught to a lay person who does not have any professional qualifications, skills or training.

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

When your doctor recommends either home health or hospice care, he or she must contact Anthem Blue Cross at **1-800-274-7767** for pre-authorization.

Services in Your Home

The Plan covers the following services when rendered in the patient's home, provided that the services are Medically Necessary Covered Health Services and are not considered custodial care, as determined by Anthem Blue Cross:

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

Hospice Facility

Medically Necessary Covered Health Services in a hospice facility are covered when a patient in the latter stages of a terminal illness is formally admitted to an inpatient hospice program and Medical Management has approved the admission.

The following inpatient hospice services are covered:

- Bed, board and general nursing care.
- Medical care provided by other professional providers employed by the facility.
- Hospice facility services and supplies.
- Family counseling related to the patient's illness.
- Bereavement counseling for the family after the patient's death.

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

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

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

Hospital Care — Inpatient

Inpatient HOSPITAL care is covered at 100% after a $100 copayment and after the annual deductible has been met. Pre-authorization is required for non-emergency care, with a penalty of $300 applied if no pre-authorization

is obtained. When services are performed by a NETWORK PROVIDER, your provider will contact Anthem Blue Cross Medical Management for pre-authorization. When services are performed by a NON-NETWORK PROVIDER, it is your responsibility to contact Anthem Blue Cross Medical Management for pre-authorization or make sure that your provider has obtained the necessary pre-authorization. See "Medical Management Programs Under the NAP and CAP." The hospital copayment does not apply to the annual deductible.

Covered inpatient hospital services include:

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

Childbirth

Under federal law, the duration of benefits provided for any hospital stay in connection with childbirth for a mother or newborn child may not be restricted to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section. However, this 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 baby earlier than 48 hours (or 96 hours, as applicable).

Hospital Care — Outpatient

Covered outpatient HOSPITAL services include:

- Outpatient surgical services. This includes Medically Necessary Covered Health Services rendered in a freestanding AMBULATORY SURGICAL CENTER, a short-STAY surgical unit or an outpatient department of a hospital.
- Emergency hospital outpatient services for the first visit for emergency care and treatment of a sudden and unforeseeable illness or injury which, if not immediately diagnosed and treated, could be life-threatening or cause serious harm to bodily function.
- Medically Necessary Outpatient Covered Health Services for radiation therapy, chemotherapy and hemodialysis treatment.

Organ and Tissue Transplants

Organ and tissue transplants are covered at 100% of the NEGOTIATED RATE, after the deductible has been met, when pre-authorized by Anthem Blue Cross and when performed at an Anthem Blue Cross Center of Medical Excellence (CME) facility or at a facility authorized by Anthem Blue Cross for kidney and cornea transplants. There is no coverage for non-Center of Medical Excellence (non-CME) facilities or non-network facilities unless at a facility approved by Anthem Blue Cross for kidney and cornea transplants or as otherwise authorized by Anthem Blue Cross. Pre-authorization is required for all transplant services.

Benefits are available for the following organ and tissue transplants when the transplant is ordered by a PHYSICIAN, meets the definition of a Covered Health Service and is not an unproven, experimental, or investigational service, as described under "What the Anthem NAP and Anthem CAP Don't Cover."

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

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

Bone Marrow Donor Search

Pre-authorization is required for bone marrow donor search services. Bone marrow donor search services are covered at 100% after deductible, when you use network providers at a CME. This search is only necessary when a family donor is not found. The maximum benefit per search is $30,000. Bone marrow donor search services are not covered out of network.

Centers of Medical Excellence (CME) Transplant Facilities

In California, Anthem Blue Cross has established a Centers of Medical Excellence (CME) network of transplant facilities to provide services for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures). Equivalent approved transplant facilities are located outside of California.

CMEs are health care providers designated by Anthem Blue Cross as selected facilities for specified medical services. A provider participating in a CME network has a CME Agreement in effect with Anthem Blue Cross at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. CMEs agree to accept the CME negotiated rate as payment in full for covered services. A participating provider in the Anthem Blue Cross PPO network is not necessarily a CME. A provider's participation in the Anthem Blue Cross PPO network or other agreement with Anthem Blue Cross is not a substitute for a CME Agreement.

Obtain Authorization from Anthem Blue Cross' Authorization Program

Authorization is required for all transplant services. You must call **Pre-Authorization and Pre-Service** at **1-800-274-7767** as soon as the possibility of a transplant arises. The Authorization Program will arrange for a pre-

transplantation evaluation to be performed at a CME transplant facility. The Authorization Program also can discuss your benefit options and any special transplant guidelines.

Travel Expenses

You may be eligible to receive reimbursement for some or all of your travel expenses associated with undergoing an organ transplant. For more information, see "Transportation and Lodging."

Prescription Drugs

Inpatient Prescription Drugs

Prescription drugs you receive while you are hospitalized, or "inpatient" drugs, are covered by your Anthem Blue Cross medical plan at 100%.

Outpatient Prescription Drugs

Prescriptions dispensed and filled on an outpatient basis are covered by Express Scripts, as described in the section entitled *Prescription Drug Coverage for the NAP and CAP*. Outpatient drugs are not covered by the medical provisions of the Plan administered by Anthem Blue Cross, unless dispensed as an infusion drug or injection that requires the expertise of trained medical personnel.

Professional Services

The following professional services are covered, if deemed to be Medically Necessary Covered Health Services as determined by Anthem Blue Cross:

- Services of a PHYSICIAN, surgeon or assistant surgeon
- Services of an anesthetist or anesthesiologist in connection with surgery
- Services of a consulting physician when requested by your doctor
- Constant care services rendered by a physician when you are in critical condition
- Physician visits to a HOSPITAL or SKILLED NURSING FACILITY during a covered inpatient confinement
- Visits to your doctor's office or physician house calls for treatment of illness, disease or injury
- Radiation therapy
- Outpatient diagnostic X-rays and lab exams
- Injections, inoculations and immunizations
- Physician services in the outpatient department of a hospital, ambulatory surgical facility or short-STAY surgical unit
- Routine physical exams
- Routine or diagnostic Pap smears and mammograms (covered by X-ray/lab benefit)
- Well-baby care.
- Services of a licensed physical therapist for a covered inpatient hospital or skilled nursing facility confinement.

Mental Health Care and Substance Use Disorder Treatment

Only detoxification that is considered to be medical care and that is deemed to be a Medically Necessary Covered Health Service is covered by the medical portion of the Plan, administered by Anthem Blue Cross. Mental health care and substance use disorder treatment are covered under the separate Mental Health and Substance Use Disorder provisions of the Plan, administered by Carelon Behavioral Health.

Skilled Nursing Facility

SKILLED NURSING FACILITY services under the CAP will be reimbursed at 90% of the NEGOTIATED RATE, after deductible, when you use an Anthem Blue Cross NETWORK PROVIDER. Skilled nursing facility services received at non-network facilities are covered at 90% of the maximum allowed amount (ELIGIBLE EXPENSES) after the deductible. A HOSPITAL STAY of at least three consecutive days for the same condition is required prior to admission to a skilled nursing facility, and the admission to the skilled nursing facility must be within 30 days of your discharge from the hospital. Pre-authorization is also required, and there is a penalty of $300 if no pre-authorization is obtained. Remember, either you or your doctor must contact Anthem Blue Cross for pre-authorization (see "Medical Management Programs Under the NAP and CAP") and meet all the stated criteria for coverage.

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

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

Transportation and Lodging

- The Authorization Program will assist the patient and family with travel and lodging arrangements associated with transplant procedures, bariatric surgery or gender-affirming surgery. Expenses for travel and lodging are based on IRS guidelines and include the following: patient and companion transportation, such as airfare, train, or bus fares; hotel or apartment rentals; gas and car rentals; and taxes on covered expenses.
- Meals do not qualify for reimbursement, per IRS regulations.

For Organ Transplants

- Travel and lodging expenses are available for transplant patients only if the transplant recipient resides more than 75 miles from the Center of Medical Excellence (CME) facility or a pre-authorized participating kidney or cornea transplant facility.
- Transplant travel expense for a pre-authorized, specified transplant, including for purposes of evaluation prior to the transplant and post-discharge follow-up
- If the transplant patient is a covered dependent minor child, the transportation expenses of up to two companions will be covered.
- There is a combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.

For Bariatric or Gender-Affirming Surgery

- Travel and lodging expenses are available for bariatric or gender-affirming surgery patients only if the patient resides more than 50 miles from the Center of Medical Excellence (CME) facility or a pre-authorized participating facility performing the surgery.
- There is a combined overall lifetime maximum of $3,000 per covered person for all transportation and lodging expenses incurred by the patient and companion(s) and reimbursed under this Plan in connection with bariatric or gender-affirming procedures.

Cancer Clinical Trials

Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials, if all the following conditions are met:

- The treatment provided in a clinical trial must either:

  Involve a drug that is exempt under federal regulations from a new drug application, or

Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.

- You must be diagnosed with cancer to be eligible for participation in these clinical trials.
- Participation in such clinical trials must be recommended by your *physician* after determining participation has a meaningful potential to benefit the *member*.
- For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the *plan*, including health care services which are:

- Typically provided absent a clinical trial.
- Required solely for the provision of the investigational drug, item, device or service.
- Clinically appropriate monitoring of the investigational item or service.
- Prevention of complications arising from the provision of the investigational drug, item, device, or service.
- Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include the costs associated with any of the following:

- Drugs or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
- Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
- Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
- Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the *plan*.
- Health care services customarily provided by the research sponsors free of charge to *members* enrolled in the trial.

Note: You will be financially responsible for the costs associated with non-covered services.

Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to Independent Medical Review as described in Grievance Procedures.

- Coverage for routine mammographies (given as preventative measures to detect problems when a physician does not have a specific reason to suspect a medical problem), in accordance with Anthem Blue Cross' standard administrative policies. Diagnostic mammographies, which are given when there is a suspected problem, are also covered.
- Coverage for mastectomies in accordance with the Women's Health and Cancer Rights Act, as described below. Notify Anthem Blue Cross five business days before receiving services. By notifying Anthem Blue Cross, it can be verified whether a service is a reconstructive procedure or a cosmetic one.

Other Covered Services and Supplies

Other covered services and supplies include:

- Outpatient professional nursing services of a registered nurse (R.N.), licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.) that are certified as Medically Necessary Covered Health Services by your PHYSICIAN.
- Services of a licensed midwife working under the direction of a physician. Does not include services of a lay midwife or a doula.

- Medically Necessary Covered Health Services of a licensed physical or occupational therapist, when provided by someone other than a close relative or someone who resides in your home, when ordered by a physician, and when judged by the physician to be subject to significant improvement through such therapy. The therapy must be expected to result in significant, objective, measurable physical improvement in the covered person's condition within two months of the start of the treatment. Services may be reviewed for medical necessity and must be deemed medically necessary to be covered. After 24 visits in a calendar year, pre-authorization is required. Both physical therapy and occupational therapy visits will be counted on a combined basis when calculating the first 24 visits each calendar year.
- Non-experimental inpatient drugs and medicines which are approved by the Food and Drug Administration (FDA).
- Non-human and artificial limbs or eyes, when determined to be a Medically Necessary Covered Health Service.
- Rental or purchase of durable medical equipment (including prosthetic and orthotic devices, except foot orthotics, which are excluded from coverage) that is ordered by a physician, approved by Anthem Blue Cross, determined by Anthem Blue Cross to be a Medically Necessary Covered Health Service, and is to be used solely by the patient. Pre-authorization is required for the purchase or cumulative rental of durable medical equipment for which the total price is equal to or greater than $1,000; there will be a $300 penalty if pre-authorization is not obtained. If an item is rented, the rental price for the entire rental period cannot be more than the purchase price. The rented item must be returned if the member switches medical plans. Necessary repairs and maintenance of purchased equipment are also covered if not provided under a manufacturer's warranty or purchase agreement.
- Wigs and toupees for alopecia areata or alopecia resulting from chemotherapy or radiation therapy; limit of one wig or toupee every two years.
- Initial pair of eyeglasses or contact lenses prescribed by a doctor after eye surgery; eyeglasses or lenses when needed to replace loss of the natural lens.
- Rental of dialysis equipment and all Medically Necessary Covered Health Services and supplies required for hemodialysis treatment.
- Oxygen, including its administration.
- Short-term speech therapy services rendered by a certified speech therapist when required due to surgery, illness, injury or previous therapeutic processes, when ordered by a physician, and when judged by the physician to be subject to significant improvement through such therapy. Speech therapy due to functional nervous disorders is not covered; see "What the Anthem NAP and Anthem CAP Don't Cover." The therapy must be expected to result in significant, objective, measurable physical improvement in the covered person's condition within two months of the start of the treatment. Services may be reviewed for medical necessity and must be deemed medically necessary to be covered. After 24 visits in a calendar year, pre-authorization is required for additional visits in the same calendar year.
- Mental health and substance use disorder treatment benefits are covered under the Plan, but these benefits are available through the Mental Health/Substance Use Disorder provisions of the Plan administered by Carelon Behavioral Health, rather than Anthem Blue Cross. See *Mental Health and Substance Use Disorder Coverage for LTD Plans* for more information.
- Applied Behavioral Analysis (ABA) is covered under the Plan, but these benefits are available through Carelon Behavioral Health. See *Mental Health and Substance Use Disorder Coverage for LTD Plans* for more information.
- Diabetes self-management education programs.
- Surgery to change an individual's appearance when the purpose is:

  to correct the result of an ACCIDENTAL INJURY; or

  to treat a condition, including a birth defect, that impairs the function of a body organ.
- Diagnostic procedures for the prenatal diagnosis of genetic disorders of the fetus when authorized by a physician in the case of high-risk pregnancy.

- Surgical treatment of morbid obesity when authorized by a physician and approved by Anthem Blue Cross, when surgical treatment of morbid obesity is necessary to treat another life-threatening condition involving morbid obesity, and when it has been documented that non-surgical treatments of the morbid obesity have failed. Travel expense benefit of up to $3,000 is also available if certain criteria is met in connection with bariatric surgery (see "Transportation and Lodging").
- INFERTILITY treatments, up to a lifetime maximum of $7,000 combined for all plans administered by Anthem Blue Cross or any prior claim administrators. The benefit includes, but is not limited to, in vitro fertilization services, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and microinjection techniques. Services provided must be considered safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications.
- Gender-affirming surgery, if the surgery meets all the criteria for being deemed Medically Necessary by Anthem Blue Cross. Travel expense benefit of up to $3,000 is also available if certain criteria is met in connection with gender-affirming surgery (see "Transportation and Lodging").

Other Important Information about Anthem NAP and CAP

This section provides important information that applies under both the Anthem NAP and Anthem CAP medical options for LTD participants, including:

- Medical Management Programs
- What the Plans Don't Cover
- Claims and Appeals information
- Important Notices

Medical Management Programs Under the NAP and CAP

Not Applicable for Secondary Coverage

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

Benefits are provided only for medically necessary and appropriate services. Medical management programs are designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out-of-pocket expenses. The Medical Management Programs at Anthem Blue Cross include the Utilization Review Program, Authorization Program and Personal Case Management. The Utilization Review Program applies to inpatient HOSPITAL admissions. The Authorization Program applies to certain specialized services or treatments (e.g., organ and tissue transplants, home health care, or admissions to a SKILLED NURSING FACILITY.) The Personal Case Management Program helps you coordinate and manage long-term intensive medical care.

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

Utilization Review Program

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

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

Utilization Review Requirements

Utilization reviews are required for:

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

Review Stages

There are three stages of utilization review:

- **Pre-Service review** determines the medical necessity and appropriateness of scheduled, non-emergency inpatient hospital admissions.
- **Concurrent review** determines whether services are medically necessary and appropriate when pre-service review is not required or when Anthem Blue Cross is notified while service is ongoing, for example, after an emergency admission to the hospital.
- **Retrospective review** is performed to review services that have already been provided.

  This applies in cases when pre-authorization, pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

Effect on Benefits

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

- The appropriate utilization reviews must be performed in accordance with the Plan.

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

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

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

How to Obtain Utilization Reviews

Remember, when your physician is a NETWORK PROVIDER, it is your physician's responsibility to confirm that the review has been performed. When your physician is a non-network provider, it is your responsibility to confirm that the review has been performed. If the review is not performed, your benefits may be reduced, and penalties applied, as described above under "Effect on Benefits."

Pre-Service Reviews

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

- For all scheduled services that are subject to utilization review, you or your physician must initiate the pre-service review at least five working days prior to when you are scheduled to receive services.

- Physicians who are network providers will initiate the review on your behalf. A non-network provider may initiate the review for you, or you may call Anthem Blue Cross directly. The number for **pre-authorization and pre-service review** is **1-800-274-7767**. This number is printed on your ID card.
- If you obtain certification for a service but the certified service is not rendered within 60 days of obtaining the certification, or if the nature of the service changes, a new pre-service review must be obtained.
- Anthem Blue Cross will certify services that are medically necessary and appropriate. For inpatient hospital stays, Anthem Blue Cross will, if appropriate, certify a specific length of stay for approved services. You, your physician and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

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

  In determining "extraordinary circumstances," Anthem Blue Cross may take into account whether or not your condition was severe enough to prevent you from notifying them, or whether or not a member of your family was available to notify Anthem Blue Cross for you. You may have to prove that such "extraordinary circumstances" were present at the time of the emergency.
- When network providers have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a non-network provider to call the toll-free number printed on your identification card or you may call directly. The toll-free number for pre-authorization and pre-service review is 1-800-274-7767. This number is printed on your ID card.

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

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

Retrospective Reviews

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

Authorization Program

The Authorization Program provides prior authorization for certain "special services." When your PHYSICIAN is a NETWORK PROVIDER, it is your physician's responsibility to obtain authorization before you receive any service subject to the Authorization Program. When your physician is a NON-NETWORK PROVIDER, it is your responsibility to obtain authorization before you receive any service subject to the authorization process. Call Anthem Blue Cross' pre-authorization and pre-service review at 1-800-274-7767, which is printed on your ID card.

If you receive any such service and do not follow the procedures outlined in this section, your benefits will be reduced as shown under "Utilization Review Program."

Services Requiring Authorization

Pre-authorization is required to obtain benefits for:

- Organ and tissue transplants
- Transplant travel expense benefits
- Home health care*; HOSPICE*, or home hospice care*
- Admissions to a SKILLED NURSING FACILITY*
- Purchase or rental of durable medical equipment for which the total price is equal to or greater than $1,000.*

See "What the Anthem Blue Cross Plans Cover" for additional details.

* A $300 penalty is assessed if pre-authorization is not obtained.

Effect on Benefits

- A $300 penalty is assessed if pre-authorization is not obtained for the following special services: skilled nursing facility admissions; home health care; hospice or home hospice care; or the purchase or cumulative rental of durable medical equipment equal to or over $1,000.

When Authorization Will Be Provided

Organ and Tissue Transplants

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

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

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

Transplant Travel Expense Benefits

- Authorizations for transplant travel expense benefits will be provided for the recipient and one companion (up to two companions if the transplant recipient is a child) only if all of the following criteria are met:
  - The procedure is for transplantation of liver, heart, heart-lung, lung, kidney-pancreas, kidney, cornea, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures, and authorized by Anthem Blue Cross;
  - The organ transplant must be performed at a specific Center of Medical Excellence (CME) or at a pre-authorized participating kidney or cornea transplant facility); and
  - The specific CME is 50 miles with the CAP or 75 miles with the NAP or more from the recipient's home.

Home Health Care

See "Home Health Care and Hospice Care."

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

Skilled Nursing Facility

See "Skilled Nursing Facility."

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

Durable Medical Equipment

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

How to Obtain an Authorization

To obtain authorization, you or your physician must call the Anthem Blue Cross pre-authorization and pre-service review at **1-800-274-7767** prior to receiving services.

Medical Necessity Review Process

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

The review process follows the same procedures and timing as the benefit claim process. See "Claims and Appeals Process for the Anthem NAP and Anthem CAP. In addition:

- All pre-authorization, pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and Anthem Blue Cross Medical Policy. These criteria and policies are developed and approved by practicing providers not employed by Anthem Blue Cross, and are evaluated at least annually and updated as standards of practice or technology change. Requests satisfying these criteria are certified as medically necessary. Review Coordinators are able to approve most requests.
- If the request fails to satisfy these criteria or medical policies, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals who are clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting PHYSICIAN is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

- Only the Peer Clinical Reviewer may determine that the proposed services are not medically necessary or not appropriate.
- Reviewers may be Anthem Blue Cross employees or an independent third party chosen at the sole and absolute discretion of Anthem Blue Cross.
- You or your physician may request copies of specific criteria and/or medical policies by writing to the address shown on your Anthem Blue Cross identification card. Medical necessity review procedures may be disclosed to health care providers through provider manuals and newsletters.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are medically necessary is based on the clinical information provided. Payment is based on the terms of your coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage; or
- You are not eligible for coverage when the service is actually provided.

Personal Case Management (for Non-Medicare Members)

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

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

These Are Examples

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

How Personal Case Management Works

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

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

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

Alternative Treatment Plan

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

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

The Effect Personal Case Management Has on Benefits

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

Third Parties

Anthem Blue Cross reserves the right to use the services of one or more third parties in executing the performance of the services outlined in the letter of agreement. No other assignment of any rights or delegation of any duties by either party is valid without the prior written consent of the other party.

What the Anthem NAP and Anthem CAP Don't Cover

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

- Services or supplies received from a provider or supplier who is not licensed, registered or certified under state law to the extent required to provide such service or supply, or if the service or supply provided is not within the scope of the provider's license, certificate or registration.
- Services or supplies that are not Covered Health Services, which includes all services that are not Medically Necessary (see "Covered Health Services" and "Medically Necessary Services") or that are educational in nature, as determined by Anthem Blue Cross.
- Charges in excess of the maximum allowed amount (see "ELIGIBLE EXPENSES" in the *Glossary* section and "How the CAP Works"), as determined by Anthem Blue Cross.
- Services that are provided or a hospitalization that begins before coverage begins or after it ends, except as specifically noted elsewhere or unless the coverage began under another Company-sponsored medical plan.
- Hospitalization that continues after coverage has ended and after you have recovered sufficiently to be discharged, unless you are certified as totally disabled as explained in "Extended Benefits When Coverage Ends."
- Hospitalization primarily for physical therapy or other rehabilitative care, unless approved by Anthem Blue Cross as a Medically Necessary Covered Health Service, except those benefits which would have been provided had the patient been treated on an outpatient basis. For example, charges for room and board during such a hospitalization are not covered.
- Services in connection with the reversal of voluntary sterilization.
- Services or supplies in connection with custodial care. Custodial care is defined as care provided primarily to assist an individual in meeting the activities of daily living including, but not limited to, walking, bathing, dressing, eating, preparation of special diets, changing catheters, and supervision over self-administration of medications not requiring constant attention of trained medical personnel. It is care that can be taught to a lay person who does not have any professional qualifications, skills or training.
- Services or supplies which would not have been rendered or furnished if the Plan did not exist or services or supplies for which you would not have been required to pay.
- Cosmetic procedures are excluded from coverage. Procedures that correct a congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, illness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

  - Notify your claims administrator five business days before receiving services. By notifying Anthem, it can be verified whether a service is a reconstructive or a cosmetic procedure. When using a non-network provider, it is your responsibility to make sure that the review process is initiated with Anthem, either by you or by your provider.
- Services or supplies furnished in connection with cosmetic surgery or surgery performed mainly to change appearance. This includes surgery performed to treat a mental, psychoneurotic, or personality disorder through a change in appearance. The following are not considered to be cosmetic surgery:
  - Surgery to correct the result of an accidental injury;
  - Surgery to treat a condition, including a birth defect, that impairs the function of a body organ; or
  - Surgery to reconstruct a breast after a mastectomy.
- Services and supplies furnished in connection with surgical procedures for gender-affirming surgery, unless Medically Necessary.
- Personal comfort and convenience items and services such as guest meals, television rental or barber services.
- Reimbursement for meal expenses incurred in connection with the transplant or bariatric/gender-affirming surgery travel benefit.
- Medical or surgical treatment of excessive sweating (hyperhidrosis).
- Dental and orthodontia services, including braces, bridges, and guards, or X-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process, or the gums. This applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as the treatment of Temporomandibular Joint Disorders (TMJD) or malocclusion involving joints or muscles by methods including, but not limited to, crowning, wiring or repositioning teeth.
  - This exclusion does not apply to services for treatment or removal of a malignancy; physicians' services or X-ray exams for treatment of accidental injury to natural teeth ("treatment" includes the replacement of those teeth), provided the participant is covered by the Plan, the accident occurred while covered, and the treatment is received within 12 months of the accident; or surgery on the maxilla or mandible that is Medically Necessary to correct TMJD or other medical disorders.
- Maintenance chiropractic care. However, non-maintenance chiropractic services are Covered Health Services when approved and received as described under "Chiropractic Care."
- Any services in connection with medical exams or tests not connected with the care and treatment of an actual illness, disease, or injury, except services that Anthem Blue Cross as Claims Administrator determines are standard preventive or well-care services (such as annual physical examinations, mammograms and colonoscopies) and that are provided in accordance with Anthem Blue Cross' guidelines. Diagnostic procedures are covered for the prenatal diagnosis of genetic disorders of the fetus when authorized by a PHYSICIAN in the case of a high-risk pregnancy.
- Services or supplies for or in connection with:
  - Exams to determine the need for (or changes of) eyeglasses or lenses of any type;
  - Eyeglasses or lenses of any type (except replacements for loss of the natural lens, or the initial pair of eyeglasses or contact lenses after eye surgery);
  - Eye surgery such as radial keratotomy or Lasik surgery; or
  - Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services or supplies given in connection with, or related to, the surgery.
- Services or supplies furnished by the employer or a member of the participant's immediate family.
- Services that do not meet the definition of Covered Health Services.

- Any services or supplies that are considered to be "experimental" or "investigational," as determined solely by Anthem Blue Cross. EXPERIMENTAL PROCEDURES are defined as procedures that are mainly limited to laboratory and/or animal research. Investigational services include any treatment, therapy, procedure, drug, facility, equipment, device or supply that is not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of an illness, injury or condition. Investigational services also include those which require approval by the federal government or any agency thereof, or by any state governmental agency, prior to use, and where such approval has not been granted at the time the services were rendered.
- Speech therapy that is not deemed to be a Medically Necessary Covered Health Service, as determined solely by Anthem Blue Cross, including but not limited to speech therapy due to functional nervous disorders and treatment received after the first 24 visits in a calendar year that is deemed by Anthem Blue Cross to be not Medically Necessary.
- Physical and/or occupational therapy that is not deemed to be a Medically Necessary Covered Health Service, as determined solely by Anthem Blue Cross, including but not limited to treatment received after the first 24 visits in a calendar year that is deemed by Anthem Blue Cross to be not Medically Necessary. For purposes of counting the first 24 visits each calendar year, both physical therapy and occupational therapy visits will apply on a combined basis.
- Massage therapy, if performed by a massage therapist, or any services performed by a massage therapist who is not also a physician or other approved health care provider (see *Glossary for LTD Plans*). However, massage therapy performed by a physical therapist or chiropractor is covered, if deemed to be Medically Necessary by Anthem Blue Cross.
- Any services or supplies for learning disabilities, behavioral problems, intellectual disability, or hospitalization for environmental change, except for speech/occupational/physical therapy rendered in association with autism spectrum disorder and speech therapy for learning disabilities. Services and supplies in connection with mental, psychoneurotic, and personality disorders, or for substance use disorders; however, such services and supplies may be covered elsewhere under the Mental Health and Substance Use Disorder provisions of the Plan, administered by Carelon Behavioral Health. This exclusion does not apply to services and supplies for medical detoxification.
- Any services or supplies furnished in connection with foot care, unless they are determined to be Medically Necessary Covered Health Services and authorized by a physician.
- Orthopedic shoes (except when joined to braces) or shoe inserts, such as orthotics, even if recommended by your physician, except when prescribed for diabetes-related conditions.
- Charges in excess of the maximum allowed amount or Eligible Expenses, as determined by Anthem Blue Cross, or in excess of any specified limitation.
- Services or supplies that are not determined to be Covered Health Services, including any confinement or treatment given in connection with a service or supply that is not covered under the Plan.
- Exercise programs, exercise monitoring, exercise equipment, health spa programs and outpatient dietary consultations (for conditions other than bariatric surgery, diabetes and eating disorders).
- Services or supplies primarily for weight reduction or treatment of obesity, unless they are determined to be Medically Necessary Covered Health Services and authorized by a physician. This exclusion will not apply to surgical treatment involving morbid obesity if:
  - surgical treatment of morbid obesity is necessary to treat another life-threatening condition involving morbid obesity; and
  - it has been documented that non-surgical treatments of the morbid obesity have failed, and
  - surgical treatment has been approved by Anthem Blue Cross.
- Outpatient prescription drugs, unless dispensed as an infusion drug or injection that requires the expertise of trained medical personnel to dispense. (These may be covered by the Prescription Drug provisions of the Plan, administered by Express Scripts.)

- Mental health and substance use disorder treatment are not covered by the medical provisions of the Plan administered by Anthem Blue Cross. (These may be covered by the Mental Health and Substance Use Disorder provisions of the Plan, administered by Carelon Behavioral Health.)
- Heating pads and thermometers, and other over-the-counter products.
- Devices and computers to assist in communication and speech.
- Air purifiers, air conditioners and humidifiers.
- Supplies for comfort, hygiene or beautification.
- Services and supplies furnished in connection with injury or disease arising out of, or in the course of, any work for wage or profit (whether or not with the employer) if such injury or disease is covered by any Workers' Compensation law, occupational disease law or similar law. The Anthem Blue Cross Plan will provide services and supplies in connection with such injury or disease but will be entitled to reimbursement for them in accordance with rules set out in Part 2 of The Pacific Gas and Electric Company Health Care Plan for Active Employees Plan Document.
- Treatment for conditions caused by war or aggression, declared or undeclared, or international armed conflict.
- Services or supplies to the extent furnished by any law or government, unless required by law.
- Benefits provided under the Medicare section of the Social Security Act.
- Services and supplies for which coverage is available under any other Company-sponsored health plan or benefit program.
- Alternative treatments such as acupressure, aromatherapy, hypnotism, rolfing and other forms of alternative treatment, as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Charges for failure to keep a scheduled appointment, transfer of medical records, and other similar charges for which no medical treatment or services have been provided.
- Services that are educational in nature, unless specifically authorized by Anthem Blue Cross.
- Except as otherwise provided herein for preventive and well-care exams and tests, any services in connection with routine physical exams or medical exams not connected with the primary purpose of the discovery of a medical condition, disease or illness leading to treatment, such as a pre-employment medical exam or a team sports exam.
- Benefits provided under the extension of a benefits provision of other insurance policies, benefit plans, or health plan contracts.

See "Reductions/Exclusions for Duplicate Coverage."

Third-Party Exclusion

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

Claims and Appeals Process for the Anthem NAP and Anthem CAP

For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Care Plan, see *Health Care Participation*.

Filing a Claim for Benefits

Anthem Blue Cross on behalf of Anthem Blue Cross Life & Health Insurance Company is the Claims Administrator for the Network Access Plan (NAP) and the Comprehensive Access Plan (CAP) offered to employees on Long-Term Disability (LTD) and their eligible dependents who are not eligible for Medicare. As the Claims Administrator, Anthem Blue Cross contracts with a network of providers and processes claims. Anthem Blue Cross pays the

network providers directly for your Covered Health Services. You are responsible for paying copayments, coinsurance and/or deductibles to the network provider at the time of service or when you receive a bill from the provider. If a network provider bills you for a portion of any Covered Health Services that should have been covered by the plan, contact Anthem Blue Cross at **1-800-964-0530**.

When you receive Covered Health Services from a non-network provider, you are responsible for paying the provider up front and filing a claim with Anthem Blue Cross, even if your services were due to an emergency or because your network provider referred you to a non-network provider. You must file the claim in a format that contains all of the information required. Claim forms may be obtained by calling Anthem Blue Cross at **1-800-964-0530** or by accessing the Anthem Blue Cross website at **http://anthem.com/ca/pge**.

You must file a claim for payment of benefits within two years of the date of service. If a non-network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If your claim relates to an inpatient hospital stay, the date of service is the date on which your inpatient stay ends. If you don't file a claim and provide all required information to Anthem Blue Cross of California within two years of the date of service, benefits for that health service will be denied. This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of benefits from Anthem Blue Cross, you must provide Anthem Blue Cross with all of the following information.

- The member's name and address.
- The patient's name, age, and relationship to the member.
- The member identification number and group number stated on your ID card.
- An itemized bill from your provider that includes the following:
  - Patient diagnosis;
  - Date(s) of service;
  - Procedure code(s) and description of service(s) rendered;
  - Charge for each service tendered; and
  - Provider name, address, and Tax Identification Number (TIN).
- The date on which the injury or sickness began.
- A statement indicating whether or not you are enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name(s) of the other carrier(s).

Send your claim to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Payment for Non-Network Benefits

Anthem Blue Cross will make a benefit determination on non-network services. Benefits will be paid directly to you, unless either of the following is true:

- The provider notifies Anthem Blue Cross that your signature is on file allowing payment directly to the provider for administrative convenience; or
- You make a written request for the NON-NETWORK PROVIDER to be paid directly at the time you submit your claim for administrative convenience.

Anthem Blue Cross will not reimburse third parties who have purchased or who have been assigned benefits by physicians or other providers.

Benefit Determinations (Before an Appeal Is Filed)

There are various types of benefit claims. Each benefit claim can be categorized as a post-service, pre-service, urgent, or concurrent claim. Depending on the type of the claim, Anthem Blue Cross must process your claim within different time frames. The processing time frames for each type of claim are explained in this section. You or your authorized representative may file a claim.

Post-Service Claims

Post-Service claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, Anthem Blue Cross will send you a written response in the form of an Explanation of Benefits (EOB) within 30 days of receipt of the claim, provided that all required information was included with the claim. Anthem Blue Cross will notify you within this 30-day period if additional information is needed to process your claim and may request a one-time extension of no longer than 15 days and pend your claim until all required information is received.

If notified that an extension is necessary due to incomplete claim information, you will have 45 days to provide the required information to Anthem Blue Cross. If all the required information is received within the 45-day timeframe and the claim is then denied, Anthem Blue Cross will notify you of the denial within 15 days of receipt of the additional information. If you do not provide the needed information within the 45-day period, your claim will be denied.

Pre-Service Claims

Pre-Service claims are those claims for services that require notification or approval prior to receiving the services. Requests for pre-service claims that are not urgent may be requested by the network provider by calling **1-800-274-7767** or by submitting the request in writing to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

If your claim is a pre-service claim and was submitted properly with all the required information, Anthem Blue Cross will send you and your network provider written notice of its claim decision within 15 days of receipt of the claim. If you file a pre-service claim improperly, Anthem Blue Cross will notify you and the network provider that the claim was improperly filed within five days of receiving the pre-service claim and will give you information on how to correct it. If additional information is needed to process the pre-service claim, Anthem Blue Cross will notify you within 15 days of receipt of the claim that additional information is needed and may request a one-time extension of no longer than 15 days and pend your claim until all required information is received.

If notification of an extension is necessary due to incomplete claim information, you will have 45 days to provide the required information to Anthem Blue Cross. If all of the required information is received within the 45-day time frame, Anthem Blue Cross will notify you of its determination within 15 days of receipt of the additional information. If you don't provide the required information within the 45-day period, your claim will be denied.

Urgent Claims that Require Immediate Action

URGENT CARE claims are those claims that require notification or approval prior to receiving medical care and (1) could seriously jeopardize your life or health or your ability to regain maximum function, or (2) in the opinion of a PHYSICIAN with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. In these situations, you or your network provider may submit your request in writing to Anthem Blue Cross or call Anthem Blue Cross at **1-800-274-7767**.

You and your network provider will receive notice of the claim determination in writing or by telephone as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless you or your network provider fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan.

In the case of a failure to provide sufficient information, Anthem Blue Cross will notify you or your network provider as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. You or your network provider will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information.

Anthem Blue Cross will notify you or your network provider of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the plan's receipt of the specified information, or (2) the deadline to provide the additional information.

Notice of denial may be oral with written confirmation to follow within three days.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you or your network provider requests to extend the treatment as an urgent care claim, Anthem Blue Cross will make a determination on your request within 24 hours of receiving your request, provided your request is made at least 24 hours prior to the end of the approved treatment. Otherwise, your urgent care claim will be decided in accordance with the normal timeframe for urgent care claims.

If the request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Concurrent claims that are considered urgent may be submitted by calling Anthem Blue Cross at **1-800-274-7767**. Non-urgent claims may also be submitted in writing to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

To Resolve a Problem

Anthem Blue Cross has established a complaint resolution and grievance process to resolve members' problems or complaints. If you or a covered dependent has a question, problem, or complaint, you should call **1-800-964-0530** or write to the following address:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

If your question or concern is about a benefit determination, you should typically contact Member Services before filing a formal appeal. If the Member Services representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing or file an appeal. If you wish to file an appeal, you should contact Customer Service again and state that you would like to file an appeal. You may also send your written appeal to:

Anthem Blue Cross
P.O. Box 4310
Woodland Hills, CA 91365-4310

If you are appealing a pre-service urgent care claim denial, please refer to "Urgent Claims that Require Immediate Action," and contact Member Services at **1-800-964-0530** immediately. The Member Services telephone number is also shown on your ID card. Member Services representatives are available to take your call during posted business hours, Monday through Friday.

If Your Claim Is Denied

If your claim for benefits is denied, you will receive an adverse benefit determination. You are entitled to a full and fair review of the adverse benefit determination.

If your claim is denied, the adverse benefit determination (denial) will include:

- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the determination is based;
- a description of any additional material or information needed to perfect your claim and an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them, including your right to bring a civil action under Section 502(a) of ERISA following a final appeal;

- a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination or a statement that a copy of any such rule, guideline, protocol or other similar criterion will be provided, free of charge, upon request; and
- an explanation of any scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or a statement that the explanation will be provided, free of charge, upon request.

For claims involving urgent/concurrent care:

- the claims administrator's notice will also include a description of the applicable urgent/concurrent review process.

Appeals

How to Appeal a Claim Decision — Non-Urgent

If you still disagree with a claim determination after following the steps for filing a claim, you can contact Anthem Blue Cross in writing to formally appeal the claim. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from your ID card;
- The date(s) of medical service(s);
- The provider's name;
- The reason you believe the claim should be paid; and
- Any document or other written information to support your request for claim payment.

Send your appeal to:

Anthem Blue Cross
P.O. Box 4310
Woodland Hills, CA 91365-4310

Your first request to appeal the claim must be submitted to Anthem Blue Cross within 180 days of your receipt of the claim denial. You or your authorized representative may file an appeal.

Appeals Process

Two levels of appeals are provided for each claim. A qualified individual who was not involved in an earlier denial of your claim will be appointed to decide the appeal. No deference will be afforded to any prior determination. If your claim involves a medical judgment question, Anthem Blue Cross will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved and who was not involved in any prior denial determination. Upon request, Anthem Blue Cross will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal, and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

The appeal will take into account all comments, documents, records, and other information you submitted relating to the claim, without regard to whether such information was submitted or considered in a prior benefit determination.

To initiate a second appeal, you must repeat the same steps as those taken for your first claim appeal. Your second-level appeal must be submitted to Anthem Blue Cross within 60 days of your receipt of Anthem Blue Cross' first-level appeal denial.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

You and your network provider will be provided written notification of Anthem Blue Cross' decision on your appeal as follows:

- For appeals of pre-service claims, Anthem Blue Cross will conduct the first-level review and notify you of its decision within 15 days of receipt of your request to appeal the denied claim. If your first-level appeal is denied, you may request a second-level appeal review within 60 days of the date on which your first-level appeal was denied. If you request a second-level appeal review, Anthem Blue Cross will also conduct this review and notify you of its decision within 15 days of receipt of your request for a second-level appeal review.
- For appeals of post-service claims, Anthem Blue Cross will conduct the first-level review and notify you of its decision within 30 days of receipt of your request to appeal the denied claim. If your first-level appeal is denied, you may request a second-level appeal review within 60 days of the date on which your first-level appeal was denied. If you request a second-level appeal review, Anthem Blue Cross will also conduct this review and notify you of its decision within 30 days of receipt of your request for a second-level appeal review.
- If new or additional evidence is considered, relied upon, or generated in connection with your claims, Anthem Blue Cross will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse claim determination on review based on a new or additional rationale, the claims administrator will provide you, free of charge, with the rationale and with an opportunity to respond to the new or additional rationale.

Please note that Anthem Blue Cross' decision is based only on whether or not benefits are Covered Health Services, as defined by the appropriate medical plan. The determination as to whether the health service is necessary or appropriate is between you and your physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly jeopardize your life, health or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- Your appeal does not need to be submitted in writing. You or your physician should call Anthem Blue Cross at **1-800-274-7767** as soon as possible. Anthem Blue Cross will provide you with a written or oral determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- To initiate a second appeal, you must follow the same procedure as outlined under "How to Appeal a Claim Decision — Non-Urgent" or you may call Anthem Blue Cross as described in this section. Your second-level appeal must be submitted to Anthem Blue Cross within 60 days of your receipt of Anthem Blue Cross's first-level appeal decision.

If Your Appeal Is Denied

If your first- or second-level appeal is denied, the denial letter will include:

- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- a statement regarding your right to bring a civil action under Section 502(a) of ERISA following a final appeal;
- a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination or a statement that a copy of any such rule, guideline, protocol or other similar criterion will be provided, free of charge, upon request; and
- an explanation of any scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or a statement that the explanation will be provided, free of charge, upon request.

External Review

If the outcome of all mandatory appeals is adverse to you, you can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of filing a civil action with respect to your claim under Section 502(a) of ERISA. To be eligible for independent external review, your claim must involve an adverse determination for surprise bills (out-of-network emergency services, certain nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions). For information about the external review process, see "Claims and Appeals — Medical Benefits."

PG&E's Voluntary Review Process

If you are not satisfied with the claims and appeals review process completed with Anthem, you may elect to use PG&E's Voluntary Claims and Appeals Review Process for all claims other than those relating to an adverse determination for surprise bills (out-of-network emergency services, certain nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions), as described below, or elect to bring a civil action.

You have 90 days from the date of receipt of the final decision from Anthem to elect this claims and appeals review process. Initiation of the Voluntary Review Process does not restrict your ability to bring a civil action against the Plan. For claims relating to an eligible adverse determination for surprise bills, you should use the External Review process.

The first step of the Voluntary Claims and Appeals Review Process is to write to the PG&E Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include an AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PERSONAL HEALTH INFORMATION form. You can access a copy online at mypgebenefits.com (select Resources > Legal Notices), or by calling the PG&E Benefits Service Center at **1-866-271-8144**.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department - Appeals
300 Lakeside Drive
Oakland, CA 94612

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the Authorization form may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

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

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

Benefits for an ongoing course of treatment will not be reduced or terminated while an appeal is pending. However, if the appeal is denied in whole or in part, you may be financially responsible for the cost of the denied portion.

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

- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under section 502(a) of ERISA.

Requirement to File an Appeal Before Filing a Lawsuit

You must exhaust all mandatory Anthem Blue Cross appeals before you may bring a civil action under Section 502(a) of ERISA. You do not have to pursue the PG&E Voluntary Review Process.

Important 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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

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

Newborns' and Mothers' Health Protection

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

Kaiser Exclusive Provider Organization (EPO) Plan (For Non-Medicare LTD Participants)

The Kaiser Permanente Exclusive Provider Organization (Kaiser EPO) Plan is offered to eligible employees on LTD and their family members who are not eligible for Medicare. If you are an LTD employee enrolled in Kaiser, and you or an eligible dependent is eligible for Medicare, see *Kaiser Senior Advantage Plan*.

The Kaiser EPO Plan is administered under a Kaiser Exclusive Provider Organization (EPO) arrangement. The Kaiser EPO plan is a PG&E self-insured plan for non-Medicare members and is not an HMO. The plan operates in two regions within California: Kaiser Permanente – Northern Region and Kaiser Permanente – Southern Region. To be eligible to join the Kaiser EPO, you must live in a Kaiser EPO service area and cannot be eligible for

Medicare. Kaiser EPO membership may not be available throughout an entire county; precise service areas are specified by home ZIP code. Because of the ongoing nature of service territory changes, we recommend that you verify the Kaiser EPO service area availability directly with Kaiser Permanente.

See *Health Care Participation* for general information on eligibility for medical coverage, including coverage under the Kaiser EPO.

Kaiser EPO Benefit Booklet

Kaiser EPO members will receive complete information about the EPO Plan in a separate document, the Kaiser EPO benefit booklet. Kaiser Permanente will send you a copy of the Kaiser EPO benefit booklet when you first enroll in the plan, but you may also request a copy at any time by calling Kaiser Permanente Northern California at **1-800-663-1771** or Kaiser Permanente Southern California at **1-800-533-1833**. Your Kaiser EPO benefit booklet will provide detailed information about covered services, your copayments or coinsurance, referral and authorization requirements, and the claims and appeals processes. Please keep and use your Kaiser EPO benefit booklet as a reference document, along with any updates that you receive. If you have any questions about your Kaiser EPO benefit booklet or if you do not automatically receive it after you enroll, call Kaiser Permanente at the telephone number listed in your plan's Summary of Benefits at the end of this section.

This document, together with the Kaiser EPO benefit booklet, any updates to the Kaiser EPO benefit booklet you receive from Kaiser Permanente, the Open Enrollment communications material you receive from the Company on an annual basis, and any Summaries of Material Modifications (SMMs), constitute your Summary Plan Description (SPD) for your Kaiser EPO plan benefits. The information about the Kaiser EPO Plan contained in the service provider agreement between Pacific Gas and Electric Company and Kaiser Permanente shall govern in case of conflict between this chart and the benefit booklet or service provider agreement.

Additional information that is pertinent to and constitutes your SPD for the your Kaiser EPO plan benefits is included in *Health Care Participation* and *Rules, Regulations & Administrative Information*.

How the Kaiser EPO Plan Works

The Kaiser Exclusive Provider Organization (EPO) provides a full range of health care services on a prepaid basis. The plan has no deductible, but some services require copayments. Each year, the Company publishes a high-level summary of the plan's benefits in its Open Enrollment guides. To find out more about the plan's benefits, refer to the Kaiser EPO benefit booklet at mypgebenefits.com > Resources > Summary of Benefits Handbooks or call Kaiser Permanente.

When you join the Kaiser EPO, you will receive an identification card. You and your eligible family members must receive all of your medical care through Kaiser Permanente's medical groups (doctors, clinics, hospitals, and pharmacies) in order for services to be covered. You may be reimbursed when using a non-Kaiser doctor or hospital, but only in the event of an emergency that is life-threatening or likely to cause serious bodily harm. See "Summary of Benefits for Kaiser EPO Plan.

Service Area

The Kaiser EPO Plan is not offered in all counties, and availability may be limited in some counties. If you move out of the Kaiser EPO service area, you will be given the opportunity to enroll in another plan effective the first day of the month following notification of your move, provided you request re-enrollment within 31 days after the move. For re-enrollment, contact the PG&E Benefits Service Center at **1-866-271-8144**.

Continuity of Care

You may have to find a new Provider or health care facility when:

- the Plan's network changes and the Provider or facility you have is not in the new network; or
- you are already enrolled in the Plan and your Provider or facility stops participating in the Plan's network.

However, in some cases, you may be able to keep going to your current Provider or facility to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. A continuing care patient is an individual who is undergoing treatment for one of the following:

- a serious and complex condition;
- institutional or inpatient care;
- pregnancy;
- terminal illness; or
- a scheduled non-elective surgery.

Routine procedures, minor illnesses, and elective surgical procedures generally are not covered under this continuity of care provision.

If you qualify as a continuing care patient, the Plan will notify you, and you will be given the opportunity to submit a request for continuity of care. If your request is approved, you will generally be entitled to continue your care, subject to the same terms and conditions that applied when your Provider or facility was in the Plan's network, until the earlier of: (1) the end of a 90-day period that begins on the date you receive notice that you qualify as a continuing care patient, or (2) the date on which you are no longer a continuing care patient with respect to that Provider or facility.

Summary of Benefits for Kaiser EPO Plan

This section provides a high-level summary of the benefits provided by the Kaiser EPO Plan as of January 1, 2026. The information about the Kaiser EPO Plan contained in the service provider agreement between Pacific Gas and Electric Company and Kaiser Permanente shall govern in case of conflict between this chart and the benefit booklet or service provider agreement.

The Kaiser EPO Plan benefits may change periodically. You should always refer to the latest Kaiser EPO benefit booklet for up-to-date information about the benefits provided by the plan or call Kaiser Permanente Northern California at **1-800-663-1771** or Kaiser Permanente Southern California at **1-800-533-1833**. If you need additional information, including a list of Kaiser facilities and providers, contact Kaiser Permanente directly.

Medical Benefits

Summary Not Binding

The information contained in this summary is informational. No right shall accrue to you and/or your dependents because of any statement of error, or in omission from, this summary. The Kaiser EPO benefit booklet is the binding document between the health plan and its members.

General	Must use Kaiser Permanente facilities and doctors ▪ No annual deductible ▪ Annual out-of-pocket maximum: $1,500/person; no more than $3,000/family (excludes prescription drugs and infertility services) ▪ No lifetime benefit maximum ▪ No pre-existing condition exclusions
Hospital Stay	No charge

Skilled Nursing Facility	No charge to members in service area; 100-day limit per benefit period when prescribed by a plan physician; excludes custodial care
Emergency Room Care	$25 copay/visit for emergencies (waived if admitted to the hospital within 24 hours for the same condition)
Outpatient Hospital Care	$10 copay/visit for outpatient surgery $10 copay/visit for all other outpatient services
Maternity Care	No charge
Well-Baby Care	$10 copay/visit
Office Visits	▪ $10 copay/office visit ▪ No charge for home visit
Urgent Care Visits	$10 copay/visit
Routine Physical Examinations	$10 copay/visit
Immunizations and Injections	▪ Immunizations — no charge ▪ Allergy injections included in office visit ▪ $5 copay for allergy injections if no office visit ▪ $10 copay for allergy testing ▪ Allergy serum purchased separately for treatment — no charge
Eye Examinations	$10 copay/visit for screening/refraction; lenses and frames not covered
X-rays and Lab Tests	No charge
Pre-Admission Testing	No charge
Home Health Care	No charge to members in service area when prescribed by a plan physician; 100-day limit/calendar year; excludes custodial care
Hospice Care	No charge to members in service area when prescribed by a plan physician;
Outpatient Physical Therapy	$10 copay/visit; therapy is given if, in the judgment of a plan physician, significant improvement is achievable
Durable Medical Equipment	No charge to members in service area when prescribed by a plan physician; see Kaiser EPO benefit booklet for limitations and exclusions;
Chiropractic Care	$10 copay/visit; self-referral allowed; no pre-authorization required
Acupuncture	$10 copay/visit; referral required from a Kaiser physician
Hearing Aids and related expenses *Covered effective January 1, 2014*	80%; one per ear every three years
Other Benefits	Hearing exams when performed by a physician or by an audiologist at the request of a physician—$10 copay/visit. Infertility treatment – 50% of covered services, including drugs and laboratory; see Kaiser EPO benefit booklet for detailed coverage.

Prescription Drug Benefits

When you and/or your dependents are enrolled in the Kaiser EPO Plan, Kaiser Permanente provides your retail and mail-order prescription drug coverage. For specific information about drug coverage through the Kaiser EPO Prescription Drug Plan, contact Kaiser Permanente directly.

Provisions	Kaiser EPO – Prescription Drug Benefits
Prescription Drug Benefits	Retail and mail-order prescription drugs are administered by Kaiser Permanente.
Annual Prescription Drug Deductible (separate from medical plan annual deductible)	None
Annual Prescription Drug Out-of-Pocket Maximum	None
Annual or Lifetime Prescription Drug Maximum Benefit Limit	None
Retail Purchases	You pay $10 copay for up to a 100-day supply. Closed formulary
Mail-Order Purchases	You pay $10 for up to 100-day supply when obtained through Kaiser's mail-order, Closed formulary
Infertility, Sexual Dysfunction, Memory Enhancement and Contraceptive Drugs	Up to a 100-day supply; you pay $10 for contraceptives and other specialty drugs; 50% for infertility, memory enhancement, and sexual dysfunction drugs.

Mental Health and Substance Use Disorder Benefits

The following chart provides an overview of Mental Health and Substance Use Disorder (MHSUD) benefits for Kaiser EPO plan members. These benefits are administered both by Kaiser Permanente Exclusive Provider Organization and by Carelon Behavioral Health, depending on the type of care you receive.

When care is provided by Carelon Behavioral Health:

- Pre-authorization is required for inpatient and residential. Care that is not medically necessary will not be covered.

For more information on benefits provided by Carelon Behavioral Health, refer to *Mental Health and Substance Use Disorder Coverage for LTD Plans*.

Provisions	Kaiser EPO – Mental Health and Substance Use Disorder Benefits
Mental Health and Substance Use Disorder (MHSUD) Benefits	This Plan's general medical provisions also apply to Mental Health and Substance Use Disorder (MHSUD) benefits. These benefits are administered both by Kaiser Permanente and by Carelon Behavioral Health, depending on the type of care you receive. When care is provided by Carelon Behavioral Health, pre-authorization is required for inpatient and residential. Care that is not medically necessary will not be covered. Your medical and MHSUD expenses are combined when determining out-of-pocket maximums.

Provisions	Kaiser EPO – Mental Health and Substance Use Disorder Benefits
Outpatient Mental Health (Institutional & Professional, Intensive Outpatient, Day Treatment)	▪ Coverage through Kaiser ▪ $10 copay/visit (individual) ▪ $5 copay/visit (group) ▪ No visit limit
Inpatient Mental Health (Institutional, Residential Treatment Center)	Coverage through Kaiser No charge; no day limit or limit on number of stays
Outpatient Substance Use Disorder (Outpatient, Day Treatment, and Intensive Outpatient)	Coverage through Kaiser ▪ $10 copay/visit (individual) ▪ $5 copay/visit (group) ▪ No visit limit
Inpatient Substance Use Disorder (Detoxification, Inpatient and Residential Treatment)	May use Carelon Behavioral Health or Kaiser for detoxification. All other residential inpatient treatment is available through Carelon Behavioral Health' network only, not Kaiser. All Carelon Behavioral Health treatment – including residential inpatient treatment – requires pre-authorization. ▪ No charge ▪ No limit on number of stays
Applied Behavioral Analysis (ABA)	▪ No charge ▪ May use Carelon Behavioral Health or Kaiser Permanente ▪ Preauthorization required with Carelon Behavioral Health

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

Please note that Carelon Behavioral Health is the Claims Administrator for the Residential and Inpatient substance use disorder treatment included under the Kaiser EPO Plan. For more information, refer to *Mental Health and Substance Use Disorder Coverage for LTD Plans* for more information.

Other Information

Eligible Dependents and Member Rights	Refer to the complete description of eligibility, COBRA rights, Qualified Medical Child Support Order procedures and rights, ERISA rights and information, plan funding and plan continuation provisions provided elsewhere in this Summary of Benefits Handbook.
Choice of Providers	Members must use Kaiser Permanente facilities and physicians, except for emergencies or as noted in the Kaiser EPO benefit booklet. A Kaiser Permanente physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat a member's medical condition. The services and supplies must be provided, prescribed, authorized or directed by a Kaiser Permanente physician. Members may choose a primary care physician.
Plan Telephone Number	Kaiser Permanente Northern California **1-800-663-1771** Kaiser Permanente Southern California **1-800-533-1833**
Website	kp.org

Claims and Appeals

For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Care Plan for Employees on Long-Term Disability (LTD), see *Health Care Participation*.

For information on how to file a claim for benefits with respect to the Kaiser EPO plan, including the PG&E Voluntary Review Process, please refer to your Kaiser EPO benefit booklet.

Kaiser Senior Advantage Plan (For Medicare-Eligible LTD Participants)

This section provides a summary of the Kaiser Permanente Senior Advantage Plan (KPSA) offered to Medicare-eligible employees on Long-Term Disability (LTD) and/or their covered dependents who are eligible for Medicare. If you are an LTD employee and you live in the Kaiser service area and you and/or any dependents are not eligible for Medicare, you are eligible to enroll in the Kaiser EPO Plan, as described in *Kaiser Exclusive Provider Organization (EPO) Plan.*

See *Health Care Participation* for general information on eligibility for medical coverage, including coverage under KPSA.

Evidence of Coverage for Senior Advantage

Kaiser Senior Advantage members will receive an "Evidence of Coverage for Senior Advantage" from Kaiser Permanente (Senior Advantage EOC) free of charge. Your Senior Advantage EOC describes the Plan's covered services, your copayments, referral and authorization requirements, the claims and appeals procedures, provider and facility information, continuity of coverage, and other rules in detail. Please keep and use your Senior Advantage EOC as a reference document, along with any updates that you receive. If you have any questions about your Senior Advantage EOC, or if you do not automatically receive it after you enroll, call Kaiser Permanente Northern California
1-800-663-1771; Kaiser Permanente Southern California **1-800-533-1833**.

Additional information that is pertinent to your Kaiser Senior Advantage Plan benefits is included in *Health Care Participation* and *Rules, Regulations & Administrative Information*.

How the Kaiser Senior Advantage Plan Works

The Kaiser Permanente Senior Advantage Plan (KPSA) is a Medicare Advantage plan that provides a full range of health care services, including mental health/substance use disorder treatment and enhanced Medicare Part D

prescription drug coverage. In addition, PG&E's KPSA provides Senior Advantage enrollees with specified inpatient substance use disorder and Applied Behavior Analysis (ABA) mental health benefits through Carelon Behavioral Health. The plan has no deductible, but some services require copayments. Each year, the Company publishes a high-level summary of the plan's benefits in its Open Enrollment guides. To find out more about the plan's benefits, call Kaiser Permanente.

You must be enrolled in Medicare – both Parts A and B – to enroll in Kaiser Senior Advantage

There are three ways you can enroll in Medicare Parts A and B:

1. Call the Social Security Administration at **1-800-772-1213**.
2. Visit your local Social Security office.
3. Enroll online by visiting **medicare.gov**.

Once you complete your Medicare enrollment, you'll receive your Medicare Number and your Medicare A and B Enrollment Dates. These are required to complete your Automated Medicare enrollment (AME) process for the PG&E-retiree medical plans via the PG&E Benefits Portal or by call the PG&E Benefits Service Center at **1-866-271-8144**.

By completing the AME process, you are agreeing to assign your Medicare benefits (Parts A, B and D) to Kaiser Permanente, prior to the effective date. Assigning your Medicare benefits to Kaiser means you will not be able to use your Medicare benefits at any non-Kaiser facility or non-Kaiser provider's office while you are enrolled in the Senior Advantage plan, nor can you enroll in a Medicare Part D Prescription Drug Plan (PDP) outside of the Plan. You must complete and return the Senior Advantage Enrollment Form to Kaiser *prior to* the effective date of your enrollment; otherwise, your enrollment will be delayed or potentially canceled, and you will instead be switched to the Anthem Blue Cross Comprehensive Access Plan (CAP).

Shortly after you complete the Senior Advantage enrollment process, you will receive an identification card. You and your covered family members must receive all your medical care through Kaiser Permanente's medical groups (doctors, clinics, hospitals and pharmacies) in order for the services to be covered except in the following circumstances:

1. You may be reimbursed when using a non-Kaiser doctor or hospital, but only in the event of an emergency that is life-threatening or likely to cause serious bodily harm. See "Evidence of Coverage for Senior Advantage."
2. You may use a non-Kaiser doctor or facility in the Carelon Behavioral Health network when obtaining the specified inpatient substance use disorder or Applied Behavior Analysis (ABA) benefits that are provided through Carelon Behavioral Health; however, Carelon Behavioral Health pre-authorization is required by Carelon Behavioral Health in order to be covered.

Service Area

The KPSA is not offered in all counties, and availability may be limited in some counties. You cannot elect the KPSA unless you live in a Kaiser Senior Advantage service area; not all Kaiser EPO service areas also offer KPSA. Furthermore, if you are enrolled in KPSA and move out of the Senior Advantage service area, you must notify the PG&E Benefits Service Center at **1-866-271-8144** within 31 days of your move. After you move out of Kaiser's Senior Advantage service area, unless you decline continued medical coverage through PG&E, you and your Medicare-eligible dependents will be switched to the Anthem Blue Cross Comprehensive Access Plan (CAP) effective the first day of the month following notification of your move, provided you request re-enrollment within 31 days after your move. Family members who are not eligible for Medicare will be enrolled in the Anthem Blue Cross Network Access Plan (NAP) or Comprehensive Access Plan (CAP), depending on which plan is offered in your new ZIP code.

Summary of Benefits for Kaiser Senior Advantage Plan – Northern and Southern California

This section provides a high-level summary of the benefits provided by the Kaiser Senior Advantage Plan as of January 1, 2026. The information about the Kaiser Permanente Senior Advantage (KPSA) Medicare Advantage

HMO contained in the applicable Evidence of Coverage (EOC) or service provider agreement between Pacific Gas and Electric Company and the Kaiser Senior Advantage Medicare Advantage HMO or service provider shall govern in case of conflict between this chart and the EOC or service provider agreement.

Kaiser Senior Advantage benefits may change periodically. You should always refer to the latest Kaiser Permanente Senior Advantage Evidence of Coverage (KPSA EOC) for up-to-date information about the benefits provided by the plan or call **Senior Advantage** at **1-800-443-0815**. If you need additional information, including a list of Kaiser facilities and providers, contact Kaiser Permanente directly.

The information contained in this summary is informational only. No right shall accrue to you and/or your dependents because of any statement of error, or in omission from, this summary. Kaiser Senior Advantage's EOC is the binding document between the health plan and its members.

Medical Benefits

General	▪ Must use Kaiser Permanente facilities and providers ▪ No annual deductible ▪ Annual out-of-pocket maximum: ▫ $1,000/person; no more than $2,000/family (excludes prescription drugs and infertility services) ▪ No lifetime benefit maximum ▪ No pre-existing condition exclusions
Hospital Stay	No charge
Skilled Nursing Facility	No charge to members in service area for up to 100 days per benefit period when prescribed by a plan physician; excludes custodial care
Emergency Room Care	$25 copay/visit for emergencies (waived if admitted directly to the hospital within 24 hours for the same condition)
Outpatient Hospital Care	$10 copay/procedure for outpatient surgery; $10 copay/visit for all other outpatient services
Office Visits	▪ $10 copay/office visit ▪ No charge/home visit
Urgent Care Visits	▪ $10 copay/visit at a Kaiser facility in area; ▪ $25 copay/visit at non-Kaiser facility
Routine Physical Examinations	No charge
Immunizations and Injections	▪ Immunizations — no charge ▪ $10 copay for allergy testing if no office visit ▪ $3 copay for allergy injections if no office visit ▪ Allergy serum purchased separately for treatment — no charge
Eye Examinations	$10 copay/exam; $150 eyewear allowance for medically necessary eyewear every 24 months
X-rays and Lab Tests	No charge
Pre-Admission Testing	No charge

Home Health Care	No charge; see plan EOC for limitations and exclusions
Hospice Care	No charge
Outpatient Physical Therapy	$10 copay/visit
Durable Medical Equipment	No charge; see plan EOC for limitations and exclusions
Chiropractic Care	$10 copay/visit; preauthorization required; self-referral not allowed
Hearing Aids and Related Expenses	Hearing aid benefit administered by Optum Financial; 100% up to $1,000 per ear or 80% of the total cost—whichever is greater—for Medically Necessary only; one per ear every three years
Acupuncture	$10 copay/visit; preauthorization required; self-referral not allowed
Other Benefits	Hearing exams — $10 copay/visit

Prescription Drug Benefits

When you and/or your dependents are enrolled in Kaiser Permanente Senior Advantage, the plan's Part D Prescription Drug Plan provides your retail and mail-order prescription drug coverage, not Express Scripts. For specific information about drug coverage through Kaiser Senior Advantage's Part D Prescription Drug Plan, contact Kaiser Permanente Senior Advantage directly.

Provisions	Kaiser Senior Advantage North and South – Prescription Drug Benefits
General	Retail and mail-order Medicare Part D prescription drugs are administered by Kaiser Senior Advantage HMO.
Annual Prescription Drug Deductible (Separate from medical plan deductible)	None
Annual Prescription Drug Out-of-Pocket Maximum	None
Annual or Lifetime Prescription Drug Maximum Benefit Limit	None
Retail Purchases	**Medicare Part D plan** You pay $10 for up to a 100-day supply Closed formulary No annual maximum
Mail-Order Purchases	**Medicare Part D plan** You pay $10 up to a 100-day supply Closed formulary No annual maximum
Infertility, Sexual Dysfunction, Memory Enhancement and Contraceptive Drugs	Up to a 100-day supply; you pay $10 for contraceptives and other specialty drugs; 50% for infertility, memory enhancement, and sexual dysfunction drugs.

Mental Health and Substance Use Disorder (MHSUD) Benefits

The following chart provides an overview of Mental Health and Substance Use Disorder (MHSUD) benefits for Kaiser Permanente Senior Advantage plan members. These benefits are administered both by Kaiser Permanente Senior Advantage and by Carelon Behavioral Health, depending on the type of care you receive.

When care is provided by Carelon Behavioral Health, pre-authorization is required for inpatient and residential care. Care that is not medically necessary will not be covered.

For more information on benefits provided by Carelon Behavioral Health, refer to "Inpatient Substance Use Disorder/ABA Benefits for Kaiser Members."

Provisions	Mental Health and Substance Use Disorder Benefits for Kaiser Senior Advantage North and South (Medicare Advantage HMO)
General	Kaiser Permanente Senior Advantage's general medical plan provisions also apply to Mental Health and Substance Use Disorder (MHSUD) benefits. Carelon Behavioral Health. These benefits are administered both by Kaiser Permanente and by Carelon Behavioral Health, depending on the type of care you receive. When care is provided by Carelon Behavioral Health, pre-authorization is required for inpatient and residential. Care that is not medically necessary will not be covered. Your medical and MHSUD expenses are combined when determining deductibles and out-of-pocket maximums.
Outpatient Mental Health (Institutional & Professional, Intensive Outpatient, Day Treatment)	▪ Coverage through Kaiser ▪ $10 copay/visit (individual) ▪ $5 copay/visit (group) ▪ No visit limit
Inpatient Mental Health (Institutional, Residential Treatment Center)	▪ Coverage through Kaiser No charge; no day limit or limit on number of stays
	▪ Carelon Behavioral Health
Outpatient Substance Use Disorder (Outpatient, Day Treatment, and Intensive Outpatient)	Coverage through Kaiser ▪ $10 copay/visit (individual) ▪ $5 copay/visit (group) ▪ No visit limit
Inpatient Substance Use Disorder (Detoxification, Inpatient and Residential Treatment)	May use Carelon Behavioral Health or Kaiser for detoxification. All other residential and inpatient treatment is available through Carelon Behavioral Health' network only, not Kaiser. All Carelon Behavioral Health treatment – including residential inpatient treatment – requires pre-authorization. ▪ No charge for inpatient and residential services when pre-authorized by Carelon Behavioral Health ▪ No limit on number of stays
Applied Behavioral Analysis (ABA)	▪ Free, no deductible ▪ May use Carelon Behavioral Health or Kaiser Permanente ▪ Preauthorization required with Carelon Behavioral Health

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

Please note that Carelon Behavioral Health is the Claims Administrator for the Residential and Inpatient substance use disorder treatment included under the Kaiser Senior Advantage Plan. For full details on the provisions of the substance use disorder treatment benefits available through Carelon Behavioral Health, refer to *Mental Health and Substance Use Disorder Coverage for LTD Plans* for more information.

Other Information

Eligible Dependents and Member Rights	Refer to the complete description of eligibility, COBRA rights, Qualified Medical Child Support Order procedures and rights, ERISA rights and information, plan funding and plan continuation provisions provided elsewhere in this Summary of Benefits Handbook.
Choice of Providers	Members must use Kaiser Permanente facilities and physicians, except for emergencies or as noted in the Evidence of Coverage. A Kaiser Permanente physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat a member's medical condition. The services and supplies must be provided, prescribed, authorized or directed by a Kaiser Permanente physician. Members may choose a primary care physician.
Plan Telephone Number	1-800-443-0815
Website	**kp.org**

Appeals and Complaints

Eligibility & Participation

For issues relating to your eligibility to participate in Kaiser Senior Advantage, see Kaiser *Senior Advantage Plan*.

Claims and Appeals

For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Care Plan for Employees on Long-Term Disability (LTD), see *Health Care Participation*.

For information on how to file a claim for benefits with respect to the Kaiser Senior Advantage Plan, please refer to your EOC.

Glossary for LTD Plans (NAP, CAP, Kaiser EPO and Kaiser Senior Advantage)

The meanings of key terms used in the NAP, CAP, Kaiser EPO, and Kaiser Senior Advantage Plan descriptions are included in this *Glossary* section. In the *Health Care Participation* section and in the sections covering the NAP, CAP, Kaiser EPO, and Kaiser Senior Advantage plans, the first time a defined term appears in a major subsection the term is displayed in LARGE AND SMALL CAPS, to highlight that it is a defined term.

Accidental Injury

Physical harm or disability which is the result of a specific, unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Adverse Benefit Determination:

- A denial, reduction, or termination of a benefit by the Plan, a rescission of coverage by the Plan (as defined in 26 CFR 54.9815-2712T(a)(2), 29 CFR 2590.715-2712(a)(2), and 45 CFR 147.128(a)(2)), or a failure of the Plan to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of your, or your beneficiary's, eligibility to participate in the Plan; or
- A denial, reduction, or termination of a benefit by the Plan, or a failure of the Plan to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review; and a failure of the Plan to cover an item or service for which benefits are otherwise provided because such item or service is determined to be experimental or investigational or not Medically Necessary or appropriate.

Ambulatory Surgical Center

A freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Kaiser members must use a Kaiser Permanente Network facility unless otherwise stated in this Handbook.

Authorized Referral

(Anthem LTD-NAP Only)

An authorized referral occurs when you, because of your medical needs, are referred to a non-network provider, but only when:

- There is no network provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 30-mile radius of your residence;
- You are referred in writing to the non-network provider by a physician who is a participating provider, and
- The referral has been authorized by Anthem Blue Cross before services are rendered.

Clinically Stable

You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during, or as a result of, the discharge or transfer.

Effective Date

The date coverage begins under the Medical Plan.

Eligible Expenses

Eligible expenses are: (1) expenses for Covered Health Services that are covered by the Plan; (2) those that Anthem Blue Cross or Kaiser Permanente consider "Medically Necessary" for the diagnosis or treatment of an illness or injury; and (3) for Anthem members, those that do not exceed the maximum allowed amount as determined by Anthem Blue Cross or, in the case of services rendered by network providers, the negotiated rate.

Additionally, for Kaiser members, Eligible Expenses are defined as:

- for services provided by Kaiser Permanente, the charge in the relevant Kaiser Foundation Health Plan's schedule of Kaiser Permanente charges for services provided to participants;
- for services that EPO Providers (other than Kaiser Permanente) provide under a contract with Kaiser Permanente, the amount that the provider has agreed to accept as payment in full under that contract;

- for items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge you for the item if your benefits did not cover the item; and
- for all other services, the amounts that Kaiser allows for the services,

Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Anthem Blue Cross Member Services or Kaiser Permanente Customer Service.

Experimental Procedures

Procedures that are mainly limited to laboratory and/or animal research.

Home Health Agencies

Home health care providers that are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Health Care Organizations.

Kaiser members must use a Kaiser Permanente Network facility unless otherwise stated in this Handbook.

Hospice

An agency or organization primarily engaged in providing palliative care (pain control and symptom relief) to the terminally ill and providing supportive care to those persons and their families to help them cope with the patient's terminal illness. This care may be provided in the home or on an inpatient basis. A hospice must be: (1) certified by Medicare as a hospice; (2) recognized by Medicare as a hospice demonstration site; or (3) accredited as a hospice by the Joint Commission on Accreditation of Hospitals. A list of hospices meeting these criteria is available upon request by contacting Anthem Blue Cross Member Services or Kaiser Permanente Customer Service.

Kaiser members must use a Kaiser Permanente Network facility unless otherwise stated in this Handbook.

Hospital

A facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of physicians. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations. Kaiser members must use a Kaiser Permanente Network facility unless otherwise stated in this Handbook.

Infertility

A condition or status characterized by any of the following:

- A licensed physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.
- A person's inability to reproduce either as an individual or with their partner without medical intervention.
- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse.

Investigative

Procedures or medications that have progressed to limited use on humans but are not widely accepted as proven and effective within the organized medical community.

Maximum Allowed Amount

Maximum allowed amount is the maximum amount of reimbursement the claims administrator will allow for covered medical services and supplies under this plan.

Medically Necessary

Medically necessary services are those procedures, supplies, equipment or services which Anthem Blue Cross determines to be:

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

Negotiated Rate

For Anthem members, the amount network providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Prudent Buyer Plan Participating Provider Agreements and/or other Blue Card PPO Provider Agreements.

Network Provider or Facility

One of the following providers that has an agreement in effect with the Claims Administrator at the time services are rendered:

- A hospital;
- A physician;
- An ambulatory surgical center;
- A home health agency;
- A facility that provides diagnostic imaging services;
- A durable medical equipment outlet;
- A skilled nursing facility;
- A clinical laboratory
- A home infusion provider;
- An urgent care center;
- A retail health clinic;
- A hospice;
- A licensed ambulance company; or

- A licensed qualified autism service provider.

Network providers agree to accept the negotiated rate as payment for covered services. A directory of network providers is available upon request by contacting Anthem Blue Cross Member Services or Kaiser Permanente Customer Service.

Non-Network Provider or Facility

One of the following providers that, at the time services are rendered, does NOT have an agreement in effect with the Claims Administrator:

- A hospital;
- A physician;
- An ambulatory surgical center;
- A home health agency;
- A facility that provides diagnostic imaging services;
- A durable medical equipment outlet;
- A skilled nursing facility;
- A clinical laboratory;
- A home infusion therapy provider;
- An urgent care center;
- A retail health clinic;
- A hospice;
- A licensed ambulance company; or
- A licensed qualified autism service provider.

For Anthem members, only a portion of the amount which a non-network provider charges for a service may be treated as a covered expense under the Medical Plans. See "How Benefits Are Determined."

Other Health Care Provider

One of the following providers:

- A certified registered nurse anesthetist; or
- A blood bank.

The provider must be licensed to provide covered medical services according to state and local laws.

Physician

- A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
- One of the following providers, but only when the provider is licensed to practice where the care is provided; the provider is rendering a service within the scope of that license; the provider is providing a service for which benefits are specified in this booklet; and benefits would be payable if the services were provided by a physician:
  - A dentist (D.D.S.)
  - An optometrist (O.D.)
  - A dispensing optician
  - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)

- A chiropractor (D.C.)
- An acupuncturist (A.C.)
- Services obtained from the following providers are covered only by referral of a physician as defined in the first bullet above.
- A physical therapist (P.T. or R.P.T.)
- A speech pathologist
- An audiologist
- An occupational therapist (O.T.R.)
- A respiratory care practitioner (R.C.P.)
- A registered dietitian (R.D.) for the provision of diabetic medical nutrition therapy or nutrition therapy for eating disorders only

Post-Stabilization Care

For Kaiser members, post-stabilization care is medically necessary services related to your emergency medical condition that you receive after your treating physician determines that your emergency medical condition is clinically stable. Refer to your Kaiser EPO benefit booklet or Kaiser Senior Advantage EOC for more information.

Pre-Authorization

Approval obtained in advance required for some covered services. Pre-authorization is not a guarantee of payment under the Plan; all services must be medically necessary for reimbursement.

Region

For the Kaiser plans, a geographic region serviced by Kaiser Permanente. Each region contains service areas that cover a smaller geographic area.

Residential Treatment Center

An institution that provides continuous treatment for an illness related to mental health and alcohol/substance use disorders. The facility must be licensed as a residential treatment center according to state and local laws. The term residential treatment facility does not include a provider, or that part of a provider, used mainly for nursing care, rest care, convalescent care, care of the aged, custodial care, or educational care.

Service Area

For the Kaiser plans, a service area is a smaller geographic area (county or portion of a county) of a Kaiser Permanente Region.

Skilled Nursing Facility

An institution that provides continuous skilled nursing services. The facility must be licensed according to state and local laws and must be recognized as a skilled nursing facility under Medicare.

Kaiser members must use a Kaiser Permanente network facility unless otherwise stated in this Handbook.

Special Care Units

Special areas of a hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Stay

Inpatient confinement that begins when you are admitted to a facility and ends when you are discharged from that facility.

Urgent Care

The services received for a sudden, serious, or unexpected illness, injury or condition, other than one that is life threatening, that requires immediate care for the relief of severe pain or diagnosis and treatment of the condition.

Mental Health and Substance Use Disorder Coverage for LTD Plans

Carelon Behavioral Health provides mental health and substance use disorder coverage for Long-Term Disability (LTD) employees and their dependents who are enrolled in the Anthem Blue Cross-administered Network Access Plan (NAP) or Comprehensive Access Plan (CAP). Carelon Behavioral Health also provides coverage for inpatient substance use disorder treatment and Applied Behavior Analysis (ABA) services for Kaiser EPO and Senior Advantage Plan members, as described in this section.

The way you receive mental health and substance use disorder benefits ("behavioral health coverage") depends on which LTD medical plan you're enrolled in. You and your eligible dependents are automatically enrolled in the appropriate mental health and substance use disorder programs when you enroll in an LTD medical plan. Coverage begins on the same date as your medical plan coverage.

Carelon Behavioral Health, a behavioral health managed care company, is the primary administrator of the mental health and substance use disorder benefits for the Anthem Blue Cross NAP and CAP plans. Kaiser EPO and Senior Advantage members receive all mental health and *outpatient* substance use disorder coverage directly through Kaiser Permanente. However, *inpatient* substance use disorder treatment for Kaiser members is provided through Carelon Behavioral Health. For applied behavioral analysis (ABA) services and inpatient medical detoxification, Kaiser members have the option to seek coverage through either Kaiser Permanente or Carelon Behavioral Health.

This section describes the mental health and substance use disorder coverage that is provided to LTD plan participants through Carelon Behavioral Health. This section does not describe the mental health and outpatient substance use disorder coverage provided through Kaiser Permanente for Kaiser EPO and Senior Advantage members. For a summary of the mental health and substance use disorder coverage provided through Kaiser, refer to "Kaiser Exclusive Provider Organization (EPO) Plan" and/or "Kaiser Senior Advantage Plan," or for more detailed information, refer to the Kaiser EPO benefit booklet or Senior Advantage EOC, whichever is applicable.

You and your dependents may also seek services through the Employee Assistance Program (EAP), which is available to all active employees and their Eligible Dependents. For details, see the *Employee Assistance Program (EAP)*.

To differentiate the Carelon Behavioral Health behavioral health coverage from the medical coverage, the following is needed:

- The diagnosis must be in the DSM-5-TR (Diagnostic and Statistical Manual, Fifth Edition, Text Revision)
- Services must be provided by an independently licensed behavioral health provider using services codes specific to psychotherapy and psychiatry. For example:
  - If someone receives treatment for depression from his/her primary care physician (PCP) or general practitioner, it is not covered by the Carelon Behavioral Health plan because the provider is not a mental health provider.
  - If someone receives educational testing by a psychologist, it is not covered because educational testing is not covered under the mental health/substance use disorder coverage provided through Carelon Behavioral Health.

- If someone receives treatment by a psychologist for pain related to a medical condition, i.e., the diagnosis is not in the DSM-5-TR, it is not covered under the mental health/substance use disorder provisions of your LTD plan.
- If someone is treated for a drug-overdose due to a suicide attempt, the medical services (stomach pump, injections, and medical observation) are not covered by Carelon Behavioral Health; however, a psychiatric evaluation performed by a psychiatrist to evaluate the potential danger to the person being treated would be covered.

Note that your LTD plan's general medical plan provisions also apply to your Mental Health and Substance Use Disorder (MHSUD) benefit plan provisions. Your medical and mental health/substance use disorder expenses are combined when determining deductibles and out-of-pocket maximums, if applicable. There are no lifetime benefit limits, and no pre-existing exclusions.

Questions?

Do you have general questions concerning mental health and substance use disorder treatment? Contact Carelon Behavioral Health at **1-888-445-4436**.

MHSUD Coverage For NAP Members

NAP members have the option of using any licensed provider and receiving non-network benefits if the provider is not in the Carelon Behavioral Health network.

Deductibles and Limits for NAP Members*

	Carelon Behavioral Health Network Benefits	**Non-Network Benefits***
	(Care received from Carelon Behavioral Health network providers)	(Care received from any licensed provider)
Annual Deductible (Combined with Medical Deductible)	▪ $120/person; ▪ $240/two people; ▪ No more than $320/family	▪ $240/person; ▪ $480/two people ▪ No more than $680/family
Annual Out-of-Pocket Maximum (Combined with Medical Out-of-Pocket Maximum)	▪ $750/person ▪ No more than $1,500/family (includes deductible)	▪ $1,000/person ▪ No more than $2,000/family (includes deductible)
Lifetime Maximum	None	None

* Network benefits and limits may not be combined with non-network benefits and limits.

Please note that the deductibles and out-of-pocket maximums for mental health and substance use disorder treatment are combined with deductibles and out-of-pocket maximums in your medical plan.

Coinsurance and Copayments for NAP Members

The following chart summarizes your mental health benefits if you are enrolled in NAP. All benefits are based on Eligible Expenses. See "What the NAP Covers."

Maximum Allowed Amount

Maximum allowed amount is the maximum amount of reimbursement the claims administrator will allow for covered medical services and supplies under this plan.

	Carelon Behavioral Health - Administered Network Benefits	**Non-Network Benefits**
	(Care received from Carelon Behavioral Health network providers)	(Care received from any licensed provider)
Outpatient Treatment	▪ No charge for initial visit to psychiatrist for medication evaluation. ▪ $10 copay per visit (individual) ▪ $5 copay per visit (group) ▪ No visit limit	▪ 70% of maximum allowed amount No visit limit
Inpatient Hospitalization and Alternate levels of care (Partial Hospitalization, Residential Treatment and Structured or Intensive Outpatient Care)	▪ 100% after deductible ▪ $300 penalty if authorization is not obtained* ▪ No limit on the number of stays or treatment programs	▪ 70% of maximum allowed amount after deductible; ▪ $300 penalty if authorization is not obtained* ▪ No limit on the number of stays or treatment programs
Autism Applied Behavior Analysis (ABA) Applied Behavior Analysis (ABA) is a type of treatment for autism that emphasizes behavioral training and management through positive reinforcement, self-help, and social skills training. ABA is used to help improve behavior, communication, and overall function. ABA for the treatment of autism is fully covered.	Fully Covered ▪ Requires authorization by plan	

* Inpatient care and Alternate Levels of Care (medically necessary detoxification, partial hospitalization, residential treatment, and intensive or structured outpatient care) must be authorized within 48 hours of the beginning of confinement or treatment in order to avoid a $300 penalty for failure to obtain authorization.

How the MHSUD Program Works for NAP Members

NAP members have the option of seeking care through Carelon Behavioral Health's network of providers and receiving higher network benefits or seeking care with non-network providers and receiving lower non-network benefits. Neither network nor non-network outpatient care requires pre-approval or referral by Carelon Behavioral Health, although all care, whether network or non-network, must be Medically Necessary. See "Medically Necessary."

While you do not need authorization or approval for outpatient care, there is a $300 penalty for not obtaining authorization for both inpatient care and Alternate Levels of Care (partial hospitalization, residential treatment, and intensive or structured outpatient care). Inpatient care and Alternate Levels of Care (partial hospitalization, residential treatment, and intensive or structured outpatient care) must be authorized within 48 hours of the beginning of confinement or treatment to avoid a $300 penalty for failure to obtain authorization. To obtain

authorization, call **1-888-445-4436** to speak with a Carelon Behavioral Health care manager who will coordinate your case.

Whether you elect to receive network or non-network care, Carelon Behavioral Health care managers are available 24 hours a day, 7 days a week to assist you. Your case will be confidential, except as otherwise provided by law or as noted in any paperwork you may complete.

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

For more information on medical management and the authorization process, see "Medical Management Programs Under the NAP and CAP."

Network Benefits

For NAP members, the Program provides maximum benefits when you use network providers. You may call Carelon Behavioral Health at **1-888-445-4436** to obtain a list of providers in your area and have your treatment authorized, when required.

You may also find network providers yourself by accessing Carelon Behavioral Health's website for PG&E members at **carelonwellbeing.com/pge**. You can use various selection criteria, such as geographic location and provider's specialty, to help find an appropriate provider. Should you need assistance with establishing an appointment, the Carelon Behavioral Health Access Team can help you. Call the toll-free number and let the care manager know you need help.

Remember, you receive network benefits only when you use a network provider. If you receive network care, you do not need to fill out claim forms. The provider will send the claim directly to Carelon Behavioral Health for payment.

In Case of Emergency

If you or any of your covered dependents require emergency treatment and/or a hospital admission for a mental health condition, your first concern should be to seek professional help immediately. Then contact Carelon Behavioral Health within 48 hours to request network benefits for the emergency treatment. Failure to timely notify of confinement or treatment for any higher level of care (that is, inpatient care, partial hospitalization, residential treatment, intensive or structured outpatient care), will result in a $300 penalty. This penalty applies to both Mental Health and Substance Use Disorder treatment, as well as to care provided by either network or NON-NETWORK PROVIDERS.

Non-Network Benefits

Neither outpatient mental health nor outpatient substance use disorder treatment require authorization from Carelon Behavioral Health. You will, however, receive the lower non-network benefits for any non-network outpatient services that are covered by the Program. You may also need to pay the provider and then fill out and submit a claim form to Carelon Behavioral Health in order to receive reimbursement for any benefit to which you are entitled. See "Filing a Claim for Benefits."

What the MHSUD Program Covers for NAP Members

Eligible Expenses

All benefits are based on "Eligible Expenses," which are:

- expenses for Covered Health Services that are covered by the plan,
- those expenses that Carelon Behavioral Health considers medically necessary for diagnosis or treatment; and
- those that do not exceed the maximum allowed amount, as determined by Carelon Behavioral Health.

Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Carelon Behavioral Health.

Network Benefits

Mental health and substance use disorder expenses covered under the Program include:

- Outpatient treatment;
- Alternate Levels of Care
  - Partial hospitalization,
  - Residential treatment programs,
  - Intensive or structured outpatient treatment;
- Inpatient hospitalization;
- Detoxification, medically necessary (medical detoxification may be covered under Anthem); and
- Applied Behavior Analysis (ABA)

You receive network benefits only if:

- you have obtained care from a network provider;
- your treatment is medically necessary (see "Medically Necessary"); and
- the primary diagnosis is not excluded and is found within the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR).

Mental Health

To receive network benefits for any covered mental health treatment (both inpatient and outpatient), you must obtain care from a Carelon Behavioral Health network provider.

Inpatient

For network inpatient mental health benefits, after the annual deductible has been satisfied, the Program pays 100% of the cost of authorized inpatient hospitalization. If treatment is not authorized within 48 hours of the beginning of confinement, a $300 penalty will apply. There is no maximum on the number of stays.

Alternate Levels of Care

For network mental health Alternate Levels of Care, after the annual deductible has been satisfied, the Program pays 100% of the cost of partial hospitalization programs, residential treatment programs, partial hospitalization, intensive outpatient services and structured outpatient services. If treatment is not authorized within 48 hours of the beginning of confinement or treatment, a $300 penalty will apply. There is no maximum on the number of stays, programs, or services.

Outpatient

For network outpatient mental health treatment, you pay $10 a visit for outpatient individual therapy or $5 a visit for group therapy. There is no copayment for an initial visit to a psychiatrist for medication evaluation. There is no maximum on the number of visits.

Substance Use Disorder Treatment

To receive network benefits for any covered substance use disorder treatment (both inpatient and outpatient), you must obtain care from a Carelon Behavioral Health network provider.

Inpatient

For inpatient substance use disorder treatment, after the annual deductible has been satisfied, the Program pays 100% for authorized treatment. A $300 penalty applies if you fail to obtain authorization within 48 hours of the beginning of confinement. There is no limit on the number of stays.

Alternate Levels of Care

For network substance use disorder treatment Alternate Levels of Care, after the annual deductible has been satisfied, the Program pays 100% of the cost of partial hospitalization programs, residential treatment programs,

intensive outpatient services and structured outpatient services. If treatment is not authorized within 48 hours of the beginning of confinement or treatment, a $300 penalty will apply. There is no maximum on the number of stays, programs, or services.

Outpatient

For outpatient substance use disorder treatment, you pay $10 a visit for individual therapy or $5 a visit for group therapy. There is no maximum on the number of visits.

Non-Network Benefits

Mental Health

For mental health treatment, you will receive lower non-network benefits when you do not obtain care from a network provider for outpatient treatment.

Covered services for non-network mental health treatment include:

- Outpatient treatment
- Inpatient hospitalization
- Alternate Levels of Care
  - Partial hospitalization
  - Residential treatment
  - Intensive or structured outpatient programs

Your mental health non-network treatment will be covered only if:

- your treatment provider is an independently-licensed mental health practitioner such as a psychiatrist; psychologist; licensed clinical social worker (LCSW); licensed marriage and family therapist (LMFT); and psychiatric nurse (MSN);
- your treatment is medically necessary (see "Medically Necessary"), as verified by Carelon Behavioral Health throughout your treatment; and
- your primary diagnosis is not excluded and is found within the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR).

When you receive covered non-network mental health treatment, the Program pays 70% of the maximum allowed amount for inpatient hospitalization or Alternate Levels of Care (partial hospitalization, residential treatment, intensive or structured outpatient care) after the annual deductible has been satisfied. There is a $300 penalty for not obtaining authorization within 48 hours of the beginning of confinement or treatment. There is no maximum on the number of stays, programs, or services.

The Program also pays 70% of the maximum allowed amount for outpatient treatment. There is no maximum on the number of visits.

If you are hospitalized for a non-emergency condition on a non-network basis, benefits for your entire hospital stay will be paid at the non-network level — 70% of the maximum allowed amount for medically necessary treatment — and the $300 penalty for not obtaining authorization will apply.

Substance Use Disorder Treatment

Your substance use disorder treatment will be covered only if:

- your treatment provider is an independently-licensed mental health practitioner such as a psychiatrist; psychologist; licensed clinical social worker (LCSW); licensed marriage and family therapist (LMFT); and psychiatric nurse (MSN);
- your treatment is medically necessary (see "Medically Necessary"), as verified by Carelon Behavioral Health throughout your treatment; and
- your primary diagnosis is an alcohol or substance use disorder.

For substance use disorder treatment, you will receive lower non-network benefits when you do not obtain care from a network provider for outpatient treatment.

For covered outpatient substance use disorder treatment, the Plan pays 70% of maximum allowed amount. There is no limit on the number of visits.

For covered inpatient substance use disorder treatment or Alternate Levels of Care (partial hospitalization, residential treatment programs, and intensive or structured outpatient services), after the annual deductible has been satisfied, the Plan pays 70% of maximum allowed amount for authorized treatment at a non-network facility. A $300 penalty applies for inpatient or Alternate Levels of Care if you fail to obtain authorization within 48 hours of the beginning of confinement or treatment. There is no limit on the number of stays, programs, or services.

MHSUD Coverage For CAP Members

CAP members have the option of using any licensed provider and receive the same level of benefits whether or not the licensed provider is in Carelon Behavioral Health's network. All inpatient treatment and Alternate Levels of Care (partial hospitalization, residential treatment, and intensive or structured outpatient care) requires authorization from Carelon Behavioral Health. Failure to obtain authorization within 48 hours of the beginning of confinement or treatment will result in a $300 penalty.)

Deductibles and Limits for CAP Members

Annual Deductible	▪ $120/person; ▪ $240/two people ▪ No more than $320/family
Annual Out-of-Pocket Maximum	▪ $750/person ▪ No more than $1,500/family (includes deductible)
Lifetime Maximum	None

Please note that the deductibles and out-of-pocket maximums for mental health and substance use disorder treatment are combined with deductibles and out-of-pocket maximums in your medical plan.

Coinsurance and Copayments for CAP Members

All benefits are based on Eligible Expenses. See "What the NAP and CAP Cover."

Provision	Mental Health and Substance Use Disorder Benefits
Outpatient Treatment	▪ No charge for initial visit to psychiatrist for medication evaluation. ▪ $10 copay per visit (individual) ▪ $5 copay per visit (group) ▪ No visit limit
Inpatient Hospitalization and Alternate Levels of Care (Partial Hospitalization, Residential Treatment, and Intensive or Structured Outpatient Services)	▪ $100% after deductible ▪ $300 penalty if authorization is not obtained* ▪ No limit on the number of stays
Autism Applied Behavior Analysis (ABA) Applied Behavior Analysis (ABA) is a type of treatment for autism that emphasizes behavioral training and management through positive reinforcement, self-help, and social skills training. ABA is used to help improve behavior, communication, and overall function. ABA for the treatment of autism is fully covered.	Fully Covered Requires authorization by plan

* Inpatient care and Alternate Levels of Care (medically necessary detoxification, partial hospitalization, residential treatment, and intensive or structured outpatient care) must be authorized within 48 hours of the beginning of confinement or treatment in order to avoid a $300 penalty for failure to obtain authorization.

How the MHSUD Program Works for CAP Members

CAP members have the option of seeking care through Carelon Behavioral Health's network of providers or seeking care with non-network licensed providers. Although there may be a difference in the out-of-pocket cost to members, there is no difference in the level of benefit. No outpatient care requires pre-approval or referral by Carelon Behavioral Health. Should you need their assistance in finding a provider, however, Carelon Behavioral Health will be happy to give you names of network providers appropriate for your situation and your geographic location. Although no outpatient care requires pre-approval or referral by Carelon Behavioral Health, all care — whether it's provided by a network or non-network provider — must be medically necessary. See "Medically Necessary."

While you do not need authorization or approval for outpatient care, there is a $300 penalty for not obtaining authorization for inpatient care or Alternate Levels of Care (partial hospitalization, residential treatment, and intensive or structured outpatient care). To obtain authorization, contact call **1-888-445-4436** to speak with a Carelon Behavioral Health care manager who will coordinate your case.

Whether you elect to receive care from a network or non-network provider, Carelon Behavioral Health care managers are available 24 hours a day, 7 days a week to assist you. Your case will be confidential, except as otherwise provided by law or as noted in any paperwork you may complete.

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

You may also find network providers yourself by accessing Carelon Behavioral Health's website for PG&E members at **carelonwellbeing.com/pge**. You can use various selection criteria, such as geographic location and provider's specialty, to help find an appropriate provider. Should you need assistance with establishing an appointment with a network provider, the Carelon Behavioral Health Access Team can also help you. Call the toll-free number and let the care manager know you need help.

If you receive care from a network provider, you do not need to fill out claim forms. The provider will send the claim directly to Carelon Behavioral Health for payment. If you receive care from a non-network provider, you may need to pay the provider and then fill out and submit a claim form to Carelon Behavioral Health in order to receive reimbursement for any benefit to which you are entitled. See "Filing a Claim for Benefits."

For more information on medical management and the authorization process, see "Medical Management Programs Under the NAP and CAP."

In Case of Emergency

If you or any of your covered dependents require emergency treatment and/or a hospital admission for a mental health condition, your first concern should be to seek professional help immediately. Then contact Carelon Behavioral Health within 48 hours to request network benefits for the emergency treatment. Failure to timely notify of confinement or treatment for any higher level of care (that is, inpatient care, partial hospitalization, residential treatment, intensive or structured outpatient care), will result in a $300 penalty. This penalty applies to both Mental Health and Substance Use Disorder treatment as well as to care provided by either network or non-network providers.

What the MHSUD Program Covers for CAP Members

Eligible Expenses

All benefits are based on "Eligible Expenses," which are:

- expenses for Covered Health Services that are covered by the plan,
- those expenses that Carelon Behavioral Health considers "Medically Necessary" for diagnosis or treatment; and
- those that do not exceed the maximum allowed amount, as determined by Carelon Behavioral Health.

Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Carelon Behavioral Health.

Benefits

Mental health and substance use disorder expenses covered under the Program include:

- Outpatient treatment;
- Alternate Levels of Care
  - Partial hospitalization,
  - Residential treatment programs,
  - Intensive and structured outpatient care;
- Inpatient hospitalization;
- Detoxification, medically necessary (medical detoxification may be covered under Anthem); and
- Applied Behavior Analysis (ABA)

You receive benefits only if:

- your treatment is medically necessary (see "Medically Necessary"); and
- the primary diagnosis is a mental health or substance use disorder as found within the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR).

Mental Health

Inpatient

For mental health benefits, after the annual deductible has been satisfied, the Program pays 100% of the cost of inpatient hospitalization. A $300 penalty applies if you fail to obtain authorization within 48 hours of the beginning of confinement. There is no maximum on the number of stays.

Inpatient and Residential Levels of Care

For mental health Inpatient and Residential Levels of Care, after the annual deductible has been satisfied, the Program pays 100% of the cost of partial hospitalization programs, residential treatment programs, intensive outpatient services and structured outpatient services. If treatment is not authorized within 48 hours of the beginning of confinement or treatment, a $300 penalty will apply. There is no maximum on the number of stays, programs, or services.

Outpatient

You pay $10 a visit for outpatient individual therapy or $5 a visit for group therapy. There is no copayment for an initial visit to a psychiatrist for medication evaluation. There is no maximum on the number of visits.

Substance Use Disorder

Inpatient

For inpatient substance use disorder treatment, after the annual deductible has been satisfied, the Program pays 100% for treatment. A $300 penalty applies if you fail to obtain authorization within 48 hours of the beginning of confinement. There is no limit on the number of stays.

Alternate Levels of Care

For substance use disorder treatment Inpatient and Residential Levels of Care, after the annual deductible has been satisfied, the Program pays 100% of the cost of partial hospitalization programs, residential treatment programs, intensive outpatient services and structured outpatient services. If treatment is not authorized within 48 hours of the beginning of confinement or treatment, a $300 penalty will apply. There is no maximum on the number of stays, programs, or services.

Outpatient

You pay $10 a visit for individual therapy or $5 a visit for group therapy. There is no maximum on the number of visits.

Inpatient Substance Use Disorder/ABA Benefits for Kaiser Members

All mental health treatment for Kaiser EPO and Senior Advantage members is provided through Kaiser Permanente. All *outpatient* substance use disorder treatment for Kaiser members is also provided directly through Kaiser.

However, Carelon Behavioral Health is the Claims Administrator for all *inpatient* substance use disorder treatment benefits. In addition, Applied Behavior Analysis (ABA) benefits and inpatient medical detoxification services are available through both Carelon Behavioral Health and Kaiser Permanente.

In order to receive any of the benefits available through Carelon Behavioral Health, Kaiser EPO and Senior Advantage members must receive a referral and pre-authorization from Carelon Behavioral Health.

The substance use disorder and ABA benefits provided through Carelon Behavioral Health are described in this section. For details on the mental health, detoxification and ABA benefits provided through the Kaiser EPO Plan, refer to *Mental Health and Substance Use Disorder Coverage for LTD Plans* or your Kaiser EPO benefit booklet. Senior Advantage members should refer to "Mental Health and Substance Use Disorder (MHSUD) Benefits" or your Kaiser Senior Advantage EOC for more details.

Kaiser Permanente Benefits

For the Kaiser EPO and Senior Advantage Plans: This document, together with the Kaiser EPO benefit booklet or Senior Advantage Evidence of Coverage (EOC) you receive from Kaiser Permanente when you enroll, any updates to the Kaiser EPO benefit booklet or Senior Advantage EOC you receive from Kaiser, the Open Enrollment communications material you receive from the Company on an annual basis, and any Summaries of Material Modifications (SMMs), constitute your Summary Plan Description for your Kaiser EPO benefit booklet and/or Senior Advantage EOC benefits. In case of conflict between any documents and the Kaiser EPO benefit booklet and/or Senior Advantage EOC, the Kaiser EPO benefit booklet/Senior Advantage EOC is the binding document between Kaiser Permanente and its members, and the Kaiser EPO benefit booklet/Senior Advantage EOC will govern.

Limits for Kaiser Members

The plan limits for substance use disorder treatment for Kaiser EPO and Senior Advantage members are the same as your Kaiser medical plan's limits. For details about your plan limits, refer to your Kaiser EPO benefit booklet Or Senior Advantage EOC, whichever applies.

Coinsurance for Kaiser Members

The following chart summarizes your Carelon Behavioral Health substance use disorder treatment benefits if you are enrolled in the Kaiser EPO or Senior Advantage Plan. All benefits are based on Eligible Expenses. See "Eligible Expenses."

Provision	Substance Use Disorder Benefits for Kaiser EPO and Senior Advantage Members (Benefits Administered, and Care Coordinated, by Carelon Behavioral Health)
Inpatient Substance Use Disorder Care (Medically necessary inpatient detoxification, Inpatient and Residential Treatment)	▪ 100% ▪ Requires authorization by Carelon Behavioral Health ▪ No limit on the number of stays
Autism Applied Behavior Analysis (ABA) Applied Behavior Analysis (ABA) is a type of treatment for autism that emphasizes behavioral training and management through positive reinforcement, self-help, and social skills training. ABA is used to help improve behavior, communication, and overall function. ABA for the treatment of autism is fully covered.	Fully Covered by both Carelon Behavioral Health and Kaiser ▪ Requires authorization by Carelon Behavioral Health

Please note that Carelon Behavioral Health is the Claims Administrator only for the specified benefits that are provided through the Carelon Behavioral Health Substance Use Disorder benefit — not the benefits that are provided by Kaiser Permanente.

How the Carelon Behavioral Health Benefit Works for Kaiser Members

For Kaiser members, all inpatient or residential substance use disorder treatment requires authorization.

To obtain authorization and receive benefits, call **1-888-445-4436** to speak with a **Carelon Behavioral Health care manager** who will coordinate your case.

Carelon Behavioral Health care managers are available 24 hours a day, 7 days a week to assist you. Your case will be confidential, except as otherwise provided by law or as noted in any paperwork you may complete.

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

Although you need authorization from Carelon Behavioral Health for all treatment, you may also browse through Carelon Behavioral Health's network of providers yourself by accessing Carelon Behavioral Health's website for PG&E members at **carelonwellbeing.com/pge**. You can use various selection criteria, such as geographic location and provider's specialty, to help find an appropriate provider. Should you need assistance in establishing an appointment, the Carelon Behavioral Health Access Team can assist you. Call the toll-free number and let the care manager know you need help.

Remember, you receive benefits only when you use a network provider and when your care is authorized by Carelon Behavioral Health.

For more information on medical management and the authorization process, see "Medical Management Programs Under the NAP and CAP."

What the Carelon Behavioral Health Program Covers for Kaiser Members

Eligible Expenses

All benefits are based on "Eligible Expenses," which are:

- expenses for Covered Health Services that are covered by the plan,
- those expenses that Carelon Behavioral Health considers "Medically Necessary" for diagnosis or treatment; and
- those that do not exceed the maximum allowed amount, as determined by Carelon Behavioral Health.

Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call Carelon Behavioral Health.

Benefits

Substance use disorder treatment expenses covered under the Carelon Behavioral Health Program include:

- Residential treatment programs
- Inpatient hospitalization; and
- Medically necessary inpatient detoxification (medical detoxification may be covered under your Kaiser).

You receive benefits only if:

- your treatment is medically necessary (see "Medically Necessary") and is approved by a Carelon Behavioral Health care manager or by one of the Company's on-site EAP counselors; and
- the primary diagnosis is a substance use disorder.

All benefits require authorization from Carelon Behavioral Health.

Mental Health

Mental health benefits for Kaiser members are provided through Kaiser Permanente — not through Carelon Behavioral Health. For a summary of mental health benefits provided by Kaiser Permanente, refer to "Kaiser Exclusive Provider Organization (EPO) Plan" and/or "Kaiser Senior Advantage Plan," or for more detailed information, refer to the Kaiser EPO benefit booklet or Senior Advantage EOC, whichever is applicable. To receive benefits that are provided through Kaiser Permanente, you must go through Kaiser's processes.

Substance Use Disorder

Kaiser EPO and Senior Advantage members receive outpatient care through Kaiser Permanente, not through Carelon Behavioral Health, but they receive coverage for inpatient substance use disorder care through the program administered by Carelon Behavioral Health. Remember, you must receive authorization for inpatient or residential substance use disorder treatment through Carelon Behavioral Health. In addition, you have the option to obtain medically necessary inpatient detoxification services through either Carelon Behavioral Health or Kaiser Permanente.

Inpatient

For inpatient substance use disorder care, the Program pays 100% for authorized treatment. Authorization from Carelon Behavioral Health is required. There is no limit on the number of stays.

Autism Applied Behavior Analysis (ABA)

Applied Behavior Analysis (ABA) is a type of treatment for autism that emphasizes behavioral training and management through positive reinforcement, self-help, and social skills training. ABA is used to help improve behavior, communication, and overall function. ABA for the treatment of autism is fully covered under both Carelon Behavioral Health and Kaiser Permanente. You may elect which plan you would like to use for ABA services. Pre-authorization by Carelon Behavioral Health is required if you use Carelon Behavioral Health.

For Members of All LTD Medical Plans

The provisions described in this subsection apply to all mental health and/or substance use disorder treatment coverage provided by Carelon Behavioral Health to participants in PG&E's LTD medical plans: the Anthem NAP and CAP, the Kaiser EPO Plan, and Kaiser Senior Advantage.

Benefits are provided only for medically necessary and appropriate services. (See "Medically Necessary".)

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

Authorization

Authorization is required for all higher levels of care, including inpatient, Alternate Levels of Care (residential treatment, partial hospitalization, and intensive or structured outpatient care). Authorization establishes that the treatment has met the medical necessity criteria. Your network provider will contact Carelon Behavioral Health to provide the necessary information on which to base an authorization. If you choose to use a non-network provider, you need to make sure the provider contacts Carelon Behavioral Health in order to ensure that the services are medically necessary and therefore covered by the plan.

Further, failure to obtain authorization within 48 hours of confinement or treatment for any higher level of care (that is, inpatient care, partial hospitalization, residential treatment, or intensive or structured outpatient care) could result in the services or treatment not being covered. For this reason, it is important to obtain authorization prior to receiving services or treatment. In addition to the services potentially not being covered, for those enrolled in the NAP or CAP, there will be a $300 penalty if PRE-AUTHORIZATION is not obtained within 48 hours of confinement or treatment. This penalty applies to both Mental Health and Substance Use Disorder treatment as well as to care provided by either network or non-network providers.

Utilization Review

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

Concurrent Review

The concurrent review process provides authorization for a determined time period depending on the level of care. Prior to the end of the authorization, the provider must contact Carelon Behavioral Health to provide updated information on which Carelon Behavioral Health can base its decision to authorize or deny the treatment. Failure to obtain the authorization will result in the claim being denied. Network providers will usually contact Carelon Behavioral Health, but non-network providers may need to be reminded to do so. Remember, when using a non-network provider, you are responsible for the payment of services rendered until there is an authorization provided by Carelon Behavioral Health.

Retroactive Review

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

Medically Necessary

For the purpose of this program, medically necessary services are those that are:

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (ICD-10-CM or DSM-5-TR) that threatens life, causes pain or suffering, or results in illness or infirmity.

- Expected to improve an individual's condition or level of functioning.
- Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of the patient's needs.
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance use disorder care professionals or publications.
- Reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available.
- Not primarily intended for the convenience of the recipient, caretaker, or provider.
- No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

What the Carelon Behavioral Health MHSUD Program Does Not Cover

The following list includes, but is not limited to, the benefits the Carelon Behavioral Health program will not pay for:

- Any services performed by a non-licensed provider for mental health or substance use disorder treatment (although services for other diagnoses may be covered under the medical provisions of the NAP or CAP).
- Treatment programs for which the primary diagnosis is not a mental health condition or substance use disorder.
- Treatment programs which are not certified as medically necessary.
- Services for growth/personal exploration or learning disabilities, except for Applied Behavior Analysis (ABA).
- Mental health and/or substance use disorder treatment in a group home or halfway house.
- Treatment that does not meet the national standards established by mental health and substance use disorder treatment professionals or is deemed to be experimental.
- Court-ordered testing and treatment (unless otherwise covered and medically necessary).
- Services or supplies rendered or furnished before the patient became covered by the Program or after the patient's coverage terminated.
- Treatment for tobacco addiction.
- Ancillary services for vocational rehabilitation, behavioral training and employment counseling.
- Medical detoxification that must be provided in an acute medical unit of a hospital. (This expense may be covered under the medical plan provisions of your plan.)
- Charges in excess of maximum allowed amount, or negotiated rates in the case of a network provider (see the definition of "ELIGIBLE EXPENSES" in "Glossary for LTD Plans").
- Outpatient or take-home prescription drugs and medicines, outpatient diagnostic laboratory tests, and ambulance transportation for covered conditions. (These expenses may be covered under the medical or prescription drug plan provisions of your medical plan.)
- Any conditions for which benefits are recoverable under Workers' Compensation or any similar law.
- Treatment of family members other than as a patient (unless it is part of an approved treatment plan for the patient).
- Mental health treatment if enrolled in the Kaiser EPO or Senior Advantage plans.
- Outpatient substance use disorder and outpatient detoxification if enrolled in the Kaiser EPO or Kaiser Senior Advantage.
- Hypnotherapy;
- Second opinions (inpatient or outpatient);

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

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

More about the Carelon Behavioral Health MHSUD Program

Benefits under Other Plans

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

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

Refer to "If You Have Other Coverage" for more information on coordination of benefits.

Third-Party Exclusion

The Mental Health and Substance Use Disorder provisions administered by Carelon Behavioral Health contain an exclusion for any injury, illness or other condition for which a third party may be liable or legally responsible by reason of negligence, intentional action, or breach of legal obligation. These exclusions, limitations, and conditions are described under "Subrogation and Reimbursement" for more information on coordination of benefits.

Claims and Appeals Process for Carelon Behavioral Health

Note: For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Care Plan for LTD Employees, see "Eligibility Appeals."

Claims

Filing a Claim for Benefits

Carelon Behavioral Health is the Claims Administrator for the Mental Health and Substance Use Disorder benefits described in this section. As the Claims Administrator, Carelon Behavioral Health contracts with a network of providers and facilities and processes claims for services.

If you use a network provider or facility, the provider will send the claim directly to Carelon Behavioral Health for payment.

Participants who receive care from non-network providers (i.e., providers who do not contract with Carelon Behavioral Health) should submit claim forms to Carelon Behavioral Health. All claims must be filed within two years of the date on which services or supplies were received. Claim forms are available by calling Carelon Behavioral Health at **1-888-445-4436**.

You should only direct claims to Carelon Behavioral Health for mental health and substance use disorder treatment that is covered by Carelon Behavioral Health as indicated in this section. Claims for all other medical services should be submitted to Anthem Blue Cross or Kaiser, as applicable.

Inquiries, Benefit Clarifications, and Claims

If you have a question, an issue or complaint regarding the Mental Health and Substance Use Disorder benefits you receive through Carelon Behavioral Health, you should contact Carelon Behavioral Health at 1-888-445-4436. Many problems, complaints or potential claim issues can be resolved informally.

Most requests for services and inquiries can be handled over the telephone. If you wish to find a Carelon Behavioral Health network provider, you may call Carelon Behavioral Health at 1-888-445-4436. If you would like to receive a benefits certification, which is a pre-approval of coverage for services, you or your provider should also call 1-888-445-4436.

Benefit Determinations (Before an Appeal Is Filed)

If you have questions regarding a claim for non-network services, you should also call Carelon Behavioral Health.

There are various types of benefit claims. Each benefit claim can be categorized as a post-service, pre-service, urgent, or concurrent claim. Depending on the type of the claim, Carelon Behavioral Health must process your claim within different time frames.

The processing time frame for each type of claim is described in "Benefit Determinations (Before an Appeal Is Filed)" in "Claims and Appeals Process for the Anthem NAP and Anthem CAP." If your claim is denied, the denial notice will include the information set forth in "If Your Claim Is Denied" in "Claims and Appeals — Medical Benefits."

Appeals

Non-Urgent

If you are not satisfied with Carelon Behavioral Health's initial determination or benefit certification resolution or you believe you have received some other type of adverse benefit determination that is preventing you from receiving the services you requested in the process of trying to obtain a benefits certification, you can appeal the benefit denial/determination within 180 days of receipt of the denial or adverse determination. Your appeal may be made in writing or by calling Carelon Behavioral Health at 1-888-445-4436. If you submit your appeal in writing, you must include the following information: your name, member ID, phone number, the service for which benefit coverage has been denied, and any additional information that may be relevant to your appeal. The appeal should be sent to:

Carelon Behavioral Health
Attention: Appeals
P.O. Box 6065
Cypress, CA 90630-0065

Carelon Behavioral Health will mail you a decision notice within 15 calendar days of receipt of your appeal. The notice will include the specific reason(s) for the decision and the Plan provision(s) on which the decision was based. You have the right to receive, upon request only and at no charge, the information used by Carelon Behavioral Health to review your appeal.

If you are not satisfied with Carelon Behavioral Health's decision, you have 90 days from the date of your receipt of the decision notice to request a second level of appeal. To initiate a second level of appeal, you can submit the appeal in writing by sending it to the Carelon Behavioral Health address or you can call Carelon Behavioral Health at 1-888-445-4436. A professional committee composed of two or more members who were not involved in the initial decision will conduct the review. The decision regarding your request will be sent to you within 15 calendar days of its receipt. If at this point your appeal is denied, you can bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") or initiate PG&E's Voluntary Review Process.

Urgent

If your appeal for coverage involves urgent care, you can request an expedited review by telephoning or writing to Carelon Behavioral Health. You will be notified of the benefit determination within 72 hours of Carelon Behavioral Health's receipt of the appeal. A Medical Department representative will contact your provider to schedule a time for a telephone review of your case. Your provider will be advised of the determination at the end of the telephone review. A written notification of the decision will be sent to you and your provider within three calendar days of

the verbal notification. If you or your provider has additional information to be included in the appeal, you will need to provide the additional information within three days of the appeal request.

An urgent appeal is any claim for treatment with respect to which the application of the time periods for a non-urgent care determination could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, could subject the claimant to severe pain that cannot be adequately managed.

If you receive an adverse benefit determination on your appeal, you have the right to further appeal the decision. You have 90 days to request a second level of appeal. A professional committee composed of two or more members, or a board-certified MD Peer Advisor, who was not involved in the initial decision, will conduct the review. A benefit determination will be sent to you and your provider within 15 calendar days of your request. You may submit the appeal in writing or by calling Carelon Behavioral Health at **1-888-445-4436**.

Written appeals should be sent to the following address:

Carelon Behavioral Health
Attention: Appeals
P.O. Box 6065
Cypress, CA 90630-0065

Expedited Review for Urgent Appeals

You have the right to an expedited review for urgent appeals involving an imminent and serious threat to the health of the Member, including but not limited to severe pain, potential loss of life, limb, or major bodily functions. The request may be initiated by you, your authorized representative, or by your provider. Call Carelon Behavioral Health at **1-888-445-4436** and tell the representative that you are requesting an expedited review of an urgent appeal. Carelon Behavioral Health will notify the provider of the decision in no more than 72 hours and send the Member a written statement on the disposition or pending status of the appeal within the same 72 hours from receipt of the appeal.

Carelon Behavioral Health Post-Service Appeals

If you believe that your claims were processed or denied incorrectly, you can try to resolve the issue informally as described under "Inquiries, Benefit Clarifications, and Claims" under "Claims and Appeals Process for Carelon Behavioral Health." If this approach is unsatisfactory, you may appeal the initial claim determination. To initiate an appeal, you must write or telephone Carelon Behavioral Health at **1-888-445-4436** within 180 days of receipt of the claim processing determination. Your appeal must include the following information: your name, member ID, phone number, a copy of the denied or incorrectly processed claim and any additional information that may be relevant to your appeal. Written appeals should be sent to:

Carelon Behavioral Health
Attention: Clinical Appeals
P.O. Box 6065
Cypress, CA 90630-0065

OR

Carelon Behavioral Health
Attention: Admin Appeals
P.O. Box 1851
Hicksville, NY 11802-1851

A decision notice will be mailed to you within 30 days of receipt of your appeal by Carelon Behavioral Health. The notice will include the specific reason(s) for the decision and a reference to the Plan provision(s) on which the decision was based. You also have the right to receive, only upon request and at no charge, the information that Carelon Behavioral Health used to review your appeal. If the information you submit with your appeal is incomplete, you will be notified by letter of the additional information needed. If you do not send the information within 45 days of the date on which you received the letter, an administrative denial may be issued.

If at this point your appeal is denied, you can bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") or initiate PG&E's Voluntary Review Process.

Submitting an Appeal

You must submit your appeal within 180 calendar days following receipt of an adverse determination notice, or following any incident or action that is the subject of your dissatisfaction. Appeals may be filed telephonically, in person, in writing, by facsimile, by email or online through the Carelon Behavioral Health website, **carelonbehavioralhealth.com**. Carelon Behavioral Health will mail an appeal form to you for this purpose, and a copy of Carelon Behavioral Health's Appeals Procedure, upon request. If you wish, Carelon Behavioral Health's Member Services staff will assist in completing the Appeal form. Completed Appeal forms must be mailed to Carelon Behavioral Health at P.O. Box 6065, Cypress, California, 90630-0065. Carelon Behavioral Health will acknowledge receipt of an appeal within five calendar days of receipt of the appeal.

External Review

If the outcome of all mandatory appeals is adverse to you, you can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of filing a civil action with respect to your claim under Section 502(a) of ERISA. To be eligible for independent external review, your claim must involve an adverse determination for surprise bills (out-of-network emergency services, certain nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions). For information about the external review process, see "Claims and Appeals — Medical Benefits".

PG&E's Voluntary Review Process

If you are not satisfied with the claims and appeals review process completed with Carelon Behavioral Health, you may elect to use PG&E's Voluntary Claims and Appeals Review Process for all claims other than those relating to an adverse determination for surprise bills (out-of-network emergency services, certain nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions), as described below, or elect to bring a civil action.

You have 90 days from the date of receipt of the final decision from Carelon Behavioral Health to elect this claims and appeals review process. Initiation of the Voluntary Review Process does not restrict your ability to bring a civil action against the Plan. For claims relating to an eligible adverse determination for surprise bills, you should use the External Review process.

The first step of the Voluntary Claims and Appeals Review Process is to write to the PG&E Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include an AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PERSONAL HEALTH INFORMATION form. You can access a copy online at mypgebenefits.com (select Resources > Legal Notices), or by calling the PG&E Benefits Service Center at **1-866-271-8144**.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department - Appeals
300 Lakeside Drive
Oakland, CA 94612

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the Authorization form may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

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

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information

supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

Benefits for an ongoing course of treatment will not be reduced or terminated while an appeal is pending. However, if the appeal is denied in whole or in part, you may be financially responsible for the cost of the denied portion.

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

- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under section 502(a) of ERISA.

Requirement to File an Appeal Before Filing a Lawsuit

You must exhaust all mandatory Carelon Behavioral Health appeals before you may bring a civil action under Section 502(a) of ERISA. You do not have to pursue the PG&E Voluntary Review Process.

Prescription Drug Coverage for the NAP and CAP (for Employees on LTD)

This section describes the prescription drug coverage offered to employees on Long-Term Disability (LTD) and their dependents who are enrolled in the Network Access Plan (NAP) or the Comprehensive Access Plan (CAP) for non-Medicare-eligible employees on Long-Term Disability.

This coverage, administered by Express Scripts, Inc., provides retail and mail-order prescription drug coverage. These prescription drug benefits do not coordinate with any of the benefits administered by Anthem Blue Cross.

Kaiser Participants

Employees on LTD and their dependents who are enrolled in a Kaiser Permanent plan receive retail and mail-order prescription drug coverage directly through Kaiser rather than through Express Scripts. For more information about prescription drug coverage under the Kaiser plans, see *Kaiser Exclusive Provider Organization (EPO) Plan*, *Kaiser Exclusive Provider Organization (EPO) Plan* or *Kaiser Senior Advantage Plan*, or contact Kaiser's member services department directly.

Plan Benefits

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

	Prescription Drug Benefits for NAP and CAP Members (Administered by Express Scripts)
Retail Drug Purchases	First three 30-day fills of maintenance drugs and all 30-day fills of non-maintenance drugs: At participating pharmacy: ▪ 85% for generic ▪ 75% for brand At non-participating pharmacy: ▪ 80% for generic ▪ 70% for brand You pay extra 5% coinsurance for 4th refill and beyond of maintenance drugs Generic Incentive Provision applies*
Express Scripts Mail-Order Pharmacy	100% for drugs on Express Scripts' Low-Cost Generic List For all other mail-order drugs: 90% for generic drugs and 80% for brand-name drugs, up to a 90-day supply. Generic Incentive Provision applies*.
Generic Incentive Provision	Member is responsible for paying the difference between the price of a generic drug and a brand-name drug, plus coinsurance, if purchasing a brand-name drug when a generic version is available. Please note that any generic-brand price differential you pay is a non-covered expense and, thus, does not count towards your deductible or annual out-of-pocket maximum.
Deductible	No deductible.
Annual Out-of-Pocket Maximum	▪ $500 per person, $1,000 per family. ▪ Out-of-pocket maximum covers both retail drug plan and mail-order drug plan. Non-covered expenses, such as generic-brand price differentials and other penalties, are not eligible expenses and, thus, will not count toward your deductible or out-of-pocket maximum, nor will these expenses be covered by the Plan after your annual out-of-pocket maximum is met.
Lifetime Maximum	None
Infertility, Sexual Dysfunction	▪ You pay 50% for both retail and mail-order plans, unless medically necessary. ▪ Medically necessary drugs are covered at standard reimbursement rates. ▪ Generic Incentive Provision applies*.

*Generic Incentive Provision: If you purchase a brand-name drug when a generic is available, you'll be responsible for paying the price difference plus any required coinsurance. Note: Any generic/brand price differential you pay is a non-covered expense and therefore does not count toward your annual out-of-pocket maximum.

Express Scripts has negotiated rates with many retail pharmacies. Benefits for prescription drugs purchased at these pharmacies are paid based on these negotiated rates. The pharmacies that Express Scripts has negotiated with are called "participating" pharmacies. To receive the greatest benefit on retail prescriptions, participating pharmacies should be used. A directory of participating pharmacies can be obtained by calling Express Scripts Member Services at **1-800-718-6590** or by visiting Express Scripts' website at express-scripts.com. You also can use Express Scripts' mail-order program for your maintenance drugs.

Manufacturer rebates are earned upon participant purchase of certain prescription drugs. The value of these rebates is based on the contract that Pacific Gas and Electric Company, as Plan sponsor, has with Express Scripts. These rebates are received from Express Scripts approximately six months after the purchase of a drug.

Generic Incentive Provision

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

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

Al purchases a 30-day supply of Mevacor, a brand-name prescription drug, at the local pharmacy. He chooses not to use the generic alternative, Lovastatin.

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

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

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

Eligibility

Employees on Long-Term Disability (LTD) and their eligible dependents who are enrolled in one of the self-insured medical plans administered by Anthem Blue Cross are eligible for the Prescription Drug Plan administered by Express Scripts, Inc.

Employees on LTD and their Eligible Dependents who are enrolled in a Kaiser Permanente plan are not eligible for the Prescription Drug benefits described in this section. Kaiser members receive retail and mail-order prescription drug coverage directly through Kaiser. For more information regarding your plan's prescription drug coverage, contact the plan's member services department directly.

How the Plan Works

National Preferred Drug List

Certain prescription drugs are included on the Express Scripts National Preferred Drug List. This list, sometimes called a formulary, includes a wide selection of generic and brand-name drugs. Express Scripts maintains the Express Scripts National Preferred Drug List, including ensuring that the list is reviewed and updated regularly by an independent pharmacy and therapeutics committee. The list is continually revised by Express Scripts to ensure that the most up-to-date information is taken into account. Go to express-scripts.com or call **1-800-718-6590** to see if your prescription is on the list.

Retail Pharmacy Service

The Retail Pharmacy Service, managed by Express Scripts, helps you pay for retail prescription drugs—that is, drugs that you purchase at local pharmacies. You have coverage under the Retail Pharmacy Service only if you are on LTD and enrolled in the NAP or CAP medical plan administered by Anthem Blue Cross.

When you enroll in the NAP or CAP administered by Anthem Blue Cross, you are issued a member identification card by Express Scripts. Go to any participating pharmacy (such as CVS, Rite Aid, Walgreens, Raley's or a number of independent pharmacies), present your card identifying you as an Express Scripts member, and pay the appropriate coinsurance. You may also go to a non-participating pharmacy; however, you will be responsible for paying the entire cost of the prescription upfront and then filing a claim form for reimbursement. It is likely that a non-participating pharmacy will charge more than the pre-negotiated rates of a participating pharmacy. Reimbursement is based on the amount a participating pharmacy would have charged, minus the coinsurance amount. You may call **1-800-718-6590** or go to express-scripts.com to verify pharmacy participation.

Maintenance drugs (i.e., those you use on an ongoing basis) purchased at a participating retail pharmacy will be reimbursed for up to three 30-day supplies at 85% for generic drugs and 75% for brand-name drugs. However, for retail refills of most maintenance drugs beyond a 90 days' supply limit, the reimbursement rate for drug purchases at participating pharmacies will be 80% for generic and 70% for brand-name drugs. For example, members will be reimbursed at 85% for an initial 30-day supply of a generic maintenance drug as well as for two 30-day generic refills at a participating retail pharmacy. If the member requests a fourth prescription of the same maintenance drug at a participating retail pharmacy, the reimbursement rate will drop to 80% because the 90-day supply limit for maintenance drugs will have been exceeded. Therefore, it is suggested that members use the Express Scripts' mail-order pharmacy service for refills of maintenance drugs beyond a 90-day supply.

Here's how to use mail order for maintenance drugs:

- Ask your physician for two separate prescriptions: one prescription for a 30-day supply (to be filled at your local retail pharmacy) and one prescription for a 90-day supply (to be filled through Express Scripts' mail-order pharmacy).
- Have your 30-day prescription filled immediately at your retail pharmacy. About two weeks later (after you have used up half of your 30-day supply and have decided to continue taking this particular prescription drug), submit your 90-day prescription to Express Scripts' mail-order pharmacy. This will allow a 14-day turn-around for your mail-order prescription to be delivered to your home. Express Scripts will not issue your 90-day supply if you send your order in any sooner than this because it will still be too early to fill the prescription.

When Claim Forms Are Required

You will need to pay the full cost of your prescription and file a claim form for reimbursement if you:

- purchase drugs at a non-participating pharmacy;
- do not present your Express Scripts identification card when purchasing drugs at a participating pharmacy; or
- have other prescription drug coverage which pays first before Express Scripts and you want Express Scripts to pay second on any claim remainder. This is called a Coordination of Benefits or "COB" claim; see "If You Have Other Coverage."

A member may obtain prescription drugs from participating pharmacies without using their membership card and then seek reimbursement from Express Scripts by submitting a claim form. However, the member's reimbursement in such cases will be limited to the cost for the drug negotiated by Express Scripts and the pharmacy. Any additional amounts charged to the member by the pharmacy will be the member's responsibility.

To obtain a claim form, call Express Scripts Member Services at **1-800-718-6590** or visit Express Scripts' website at express-scripts.com. If you are a first-time visitor to **express-scripts.com**, take a minute to register. Please remember to have your member ID number and a recent prescription number handy.

Express Scripts Mail-Order Pharmacy

The Express Scripts mail-order pharmacy is available to all who are enrolled in any of the PG&E-sponsored medical plans administered by Anthem Blue Cross. and their Eligible Dependents.

This program enables you to purchase your maintenance medications, often at a savings, while having them delivered directly to your home via U.S. mail. "Maintenance" medications are those drugs that you take on a long-term or an on-going basis — in other words, those drugs that you know you'll need and can order in advance. Some examples of conditions for which maintenance medications are prescribed are high blood pressure, high cholesterol, heart disorders, diabetes, arthritis and stomach ulcers.

How the Express Scripts Mail-Order Pharmacy Service Works

With Express Scripts' mail-order pharmacy, you may obtain up to a 90-day supply of medication for each prescription. You pay 10% of the cost for each prescription filled with generic drugs, and 20% for those filled with brand-name drugs. If you elect to use a brand-name drug when a generic drug is available, you will be responsible for paying the difference between the price of the generic drug and the brand-name drug, plus coinsurance, as described under Generic Incentive Provision.

Patient Profile

When you order from the Express Scripts mail-order pharmacy for the first time, you will need to complete the mail-order form and the Express Scripts "Health, Allergy & Medication Questionnaire" (HMQ). Complete both forms and mail them, along with your original prescription, in an envelope addressed to:

Express Scripts, Inc.
P.O. Box 747000
Cincinnati, Ohio 45274-7000

The mail-order form, the HMQ and mail-order envelopes are available by calling Express Scripts Member Services at **1-800-718-6590**. You may also download the mail-order form and HMQ by accessing Express Scripts' website at express-scripts.com or on the Anthem member pages on mypgebenefits.com under Physical Health.

The purpose of the HMQ is to alert the pharmacists who are filling your prescriptions of any allergies or medical conditions that might be affected by the prescriptions you are ordering, in an effort to prevent any potentially harmful drug reactions. All information in the HMQ is confidential.

Paying Your Coinsurance

You can request that Express Scripts bill you for your coinsurance, up to $150, or you can instruct Express Scripts to bill your credit card or debit card (e.g., VISA, MasterCard, your Optum Financial health payment or personal debit card). Alternatively, you can submit payment in advance. To do so, you will need to call Express Scripts to find out the amount of your coinsurance. Then send your personal check or money order, along with your original prescription, when you send in your order.

Obtaining Your Medications

Express Scripts will mail your medications directly to your home. You will receive your medication within 14 days from the date on which Express Scripts receives your order. If you need your prescription sooner, just let Express Scripts know and, for an extra charge, your prescription will be sent via UPS or Federal Express.

Whenever possible, your prescription will be filled with a generic drug that meets the same standards as the brand name, unless your physician specifies otherwise.

Express Scripts' specialty pharmacy, Accredo Health Group, handles complex conditions such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis, which are treated with specialty medications. Specialty medications are typically injectable medications administered either by yourself or by a health care professional, and often require special handling. In addition, Express Scripts partners with Arriva Medical to fulfill prescription requests for certain drugs and supplies covered by Medicare Part B. For more information about Accredo or Arriva Medical, please call Express Scripts Member Services at **1-800-718-6590**.

Ordering Your Refills

You can order your refills by mail or by calling Express Scripts directly at **1-800-718-6590**, 24 hours a day, 7 days a week, except Thanksgiving and Christmas. For refills by mail, send the refill slip provided with your last mail-order prescription, along with your copayment, to Express Scripts, Inc., P.O. Box 747000, Cincinnati, Ohio 45274-7000. You may also order your refills online using Express Scripts' website at express-scripts.com. You can also check on the status of your refill online.

When Your Current Prescription Expires

Prescriptions expire one year from the date of issue, regardless of whether you have any refills left. You may mail your new prescription to Express Scripts, Inc., P.O. Box 747000, Cincinnati, Ohio 45274-7000. You may also have your physician fax your new prescription to Express Scripts or "e-prescribe". Ask your doctor to call **1-888-327-9791** for instructions.

What the NAP and CAP Cover

Covered expenses under the NAP and CAP consist of drugs and medicines approved by the Food and Drug Administration for general use by the public that require a written prescription by a physician and that are dispensed by a licensed pharmacist, physician, or hospital for take-home purposes. Eligible drugs and medicines include:

Is It Covered?

If you are not sure if a particular drug is covered, contact **Express Scripts** at **1-800-718-6590**. There are some prescriptions that require prior authorization.

- Drugs that require a prescription, except those specifically excluded under What The Plan Does Not Cover;
- Compound drugs that contain at least one prescription drug (exclusions apply for certain compound ingredients; contact Express Scripts to verify coverage);
- Insulin, including hypodermic needles and syringes when insulin is also purchased;
- Over-the-counter diabetic supplies, including items used for daily blood and urine sample testing (except diabetic monitors);
- Retin-A for patients through age 30 (over age 30 when medically necessary);
- Vitamins that require a prescription;
- Attention Deficit Disorder drugs (e.g., Methylphenidate, Dextroamphetamine, Methamphetamine, Dextroamphetamine/Amphetamine);
- Smoking deterrents that require a prescription (e.g., Chantix, Nicoderm, and Nicotine anti-smoking patches);
- Anorexiants with prior authorization; and
- 50% coverage for fertility, oral contraceptive and sexual dysfunction, unless these drugs are specifically authorized by your physician as medically necessary. Medically necessary drugs are covered at standard reimbursement rates.

Medically Necessary

The NAP and CAP only cover services and supplies that are Medically Necessary. For the purpose of this Plan, Medically Necessary services and supplies are those provided by a hospital, physician or other provider that: (i) have been established as safe and effective; (ii) are furnished in accordance with generally accepted professional standards to treat illness or injury, and are in accordance with the accepted standards of medical

practice in the geographic area where the services are provided; (iii) are consistent with the symptoms and diagnosis or treatment of the illness, injury or condition; (iv) are furnished at the most appropriate level that can be provided safely and effectively to the patient; and (v) are not furnished primarily for the convenience of the patient, the attending physician or other provider. Medically Necessary prescriptions will be paid at the standard level or rate of coverage.

How New Prescription Drugs Are Added

The NAP and CAP cover all prescription drugs approved by the Food and Drug Administration (FDA), as long as they are used in the FDA-approved manner and are used in accordance with manufacturers' usage guidelines. Coverage for new prescription drugs will begin upon FDA approval.

What the NAP and CAP Do Not Cover

No benefit will be provided for any expense incurred for the following drugs, medicines, substances or supplies rendered, unless specifically listed as a benefit under What the NAP and CAP Cover. Ineligible drugs, medicines, substances and supplies include:

- Drugs, medicines, substances or supplies that are not Medically Necessary (see "Medically Necessary");
- Experimental and investigational drugs;
  - Experimental or investigational drugs are not covered under the NAP and CAP. These drugs are typically new products that are still being tested by the FDA and have not been approved for general distribution under the standard prescription process. Further, drugs that are limited by federal law to investigational use and that are labeled as such are not covered. A drug may also be considered experimental if prescribed for an indication or at a dosage that is not an accepted use based on published reports in standard drug publications such as the American Hospital Formulary Service Drug Information and the United States Pharmacopeia Dispensing Information.
- Drugs or supplies that may be dispensed without a prescription;
- Medications not used in accordance with the FDA's approval specifications;
- Inpatient medications (i.e., drugs dispensed or used while you are a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent home, nursing home, or similar institution). Inpatient drugs are covered under the medical plan provisions of the NAP and CAP;
- Retin-A (unless prescribed for medical treatment other than anti-aging or for individuals under age 30; covered for individuals over age 30 when medically necessary);
- Smoking deterrents other than those listed under What the NAP and CAP Cover;
- Allergy serums;
- Therapeutic devices or appliances;
- Drugs prescribed solely for cosmetic purposes (e.g., Renova) or to promote or stimulate hair growth (e.g., Rogaine);
- Immunization agents and vaccines;
- Biologicals, blood, or blood plasma;
- Charges for the administration or injection of a drug;
- Any prescription refill in excess of the number specified by the physician, or any refill after one year from the date of the physician's original order;
- Medications to which you are entitled under any Workers' Compensation or occupational disease law;
- Medication furnished by any other drug or medical service for which no charge is made to the participant; and
- Any drug for which benefits are paid under another Company-sponsored health plan or benefit program.

For further details, see "Reductions/Exclusions for Duplicate Coverage."

Coordination of Benefits

If you are covered by another plan that has prescription drug coverage that is primary to your NAP or CAP coverage (see "If You Have Other Coverage"), you will need to fill out an Express Scripts Prescription Drug Reimbursement/Coordination of Benefits Form in order to receive any benefit, if eligible, from Express Scripts. The form is available by calling Express Scripts Member Services at 1-800-718-6590. It can also be downloaded from express-scripts.com or on the Anthem member pages at mypgebenefits.com under Physical Health.

You must submit a separate claim form for each pharmacy used and for each patient. You will need to attach documentation to the completed form. The documentation required depends on what plan is primary, as follows:

- If the primary plan is another health plan, you must attach the claim statement, or Explanation of Benefits, which you received from the primary plan to the completed Express Scripts form.
- If the primary plan is an HMO or another plan in which a co-payment or coinsurance is paid at the pharmacy, you will need to attach receipts that clearly show the amounts you paid at the pharmacy.
- If the primary plan is another Express Scripts plan, you will need to attach either the prescription receipt or the statement of benefits you received from Express Scripts.

Complete instructions are included on the Express Scripts Prescription Drug Reimbursement/Coordination of Benefits Form.

Claims and Appeals

For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Care Plan for Long-Term Disability Employees, see *Health Care Participation*.

Claims and Inquiries

Express Scripts is the Claims Administrator for the NAP and CAP prescription drug benefits. Under Express Scripts' coverage, a network of retail pharmacies is available as well as mail-order prescription drug coverage. When you go to a participating retail pharmacy, simply present your identification card and pay the appropriate coinsurance.

If you use a non-participating pharmacy, you will be responsible for paying the full cost of the prescription to the pharmacist, and then filing a claim for reimbursement. Claim forms are available by calling Express Scripts at 1-800-718-6590 or at Express Scripts' website at express-scripts.com. If you are a first-time visitor to the website, you'll need to register as a user. Please remember to have your member ID number and a recent prescription number handy when you register. Claim forms can also be obtained at mypgebenefits.com.

All claims for prescription drugs, except controlled substances, must be made within twelve months of the date on which the prescription was written by the physician. If you do not file a claim within this timeframe, your claim will be denied. All claims for controlled substances must be made within six months of the date on which the prescription was written by the physician.

If you have an issue or complaint regarding your prescription drug benefits, you should first address your concerns with Express Scripts within 60 days after the issue or complaint arises. Many problems, complaints, and potential claim issues can be resolved informally. You can address these informal complaints by phoning Express Scripts at 1-800-718-6590. Express Scripts may ask you to provide additional information or ask your physician to do so, or may try to clarify any information already provided. Express Scripts will research your issue and respond to you on its findings either in writing or by telephone within 15 days for prescriptions that have not been filled, and within 30 days for prescriptions that have already been filled and paid for.

Benefit Determinations (Before an Appeal Is Filed)

There are various types of benefit claims. Each benefit claim can be categorized as a post-service, pre-service, urgent, or concurrent claim. Depending on the type of the claim, Carelon Behavioral Health must process your claim within different time frames.

The processing time frame for each type of claim is described in "Benefit Determinations (Before an Appeal Is Filed)" in "Claims and Appeals Process for the Anthem NAP and Anthem CAP." If your claim is denied, the denial notice will include the information set forth in "If Your Claim Is Denied" in "Claims and Appeals — Medical Benefits."

Appeals

Appeals Process

Express Scripts provides two levels of appeal for each claim: a first-level appeal and a second-level appeal.

First-Level Appeals

Non-Urgent Appeal

If you are not satisfied with the decision regarding your benefit coverage or you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered denied because missing information was not timely submitted), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of the notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your PHYSICIAN). To initiate an appeal for coverage, provide in writing:

- your name;
- member ID;
- phone number;
- the prescription drug for which benefit coverage has been denied;
- the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes); and
- any additional information that may be relevant to your appeal.

This information should be mailed to the following address:

Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.

Clinical appeal requests:
Express Scripts Attn: Clinical Appeals Department
P.O. Box 66588, St Louis, MO 63166-6588

Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

Administrative appeal requests:
Express Scripts Attn: Administrative Appeals Department
P.O. Box 66587 St Louis, MO 63166-6587

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request for pre-service claims or within 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any, considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes, contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes, and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal.

Urgent Claim Appeals that Require Immediate Action

In the case of a claim for coverage involving URGENT CARE, you will be notified of the benefit determination within 24 hours of receipt of the claim. If you receive an adverse determination on your claim, you will be provided with a written statement that explains the denial and includes instructions on how to appeal that decision.

An urgent care claim is defined as a request for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your claim is considered denied and you have the right to appeal as described below.

Second-Level Appeal

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of receipt of the notice of the decision, a second level appeal. A second-level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second-level appeal, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and
- any additional information that may be relevant to your appeal.

This information should be mailed to one of the following addresses, depending on the type of review requested:

Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.

Clinical appeal requests:
Express Scripts Attn: Clinical Appeals Department
P.O. Box 66588, St Louis, MO 63166-6588

Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

Administrative appeal requests:
Express Scripts Attn: Administrative Appeals Department
P.O. Box 66587 St Louis, MO 63166-6587

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or within 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any, considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes, contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes, and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second-level appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your second-level

appeal, such information will be provided to you together with an opportunity to respond prior to issuance of any final adverse determination of this appeal. The decision made on your second-level appeal is final and binding.

If your second-level appeal is denied and you are not satisfied with the decision of the second-level appeal (i.e., your "final adverse benefit determination"), you also have the right to bring a civil action under ERISA section 502(a) and/or to submit your claim for review by an external review organization to the extent required by federal law. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination.

PG&E's Voluntary Review Process

If you are not satisfied with the claims and appeals review process completed with Express Scripts, you may elect to use PG&E's Voluntary Claims and Appeals Review Process for all claims other than those relating to an adverse determination for surprise bills (out-of-network emergency services, certain nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions), as described below, or elect to bring a civil action.

You have 90 days from the date of receipt of the final decision from Express Scripts to elect this claims and appeals review process. Initiation of the Voluntary Review Process does not restrict your ability to bring a civil action against the Plan. For claims relating to an eligible adverse determination for surprise bills, you should use the External Review process.

The first step of the Voluntary Claims and Appeals Review Process is to write to the PG&E Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include an AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PERSONAL HEALTH INFORMATION form. You can access a copy online at mypgebenefits.com (select Resources > Legal Notices), or by calling the PG&E Benefits Service Center at **1-866-271-8144**.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department - Appeals
300 Lakeside Drive
Oakland, CA 94612

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the Authorization form may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

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

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

Benefits for an ongoing course of treatment will not be reduced or terminated while an appeal is pending. However, if the appeal is denied in whole or in part, you may be financially responsible for the cost of the denied portion.

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

- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under section 502(a) of ERISA.

Requirement to File an Appeal Before Filing a Lawsuit

You must exhaust all mandatory Express Scripts appeals before you may bring a civil action under Section 502(a) of ERISA. You do not have to pursue the PG&E Voluntary Review Process.

Health Account

If you are an active employee and you are enrolled in the Health Account Plan (HAP), you are eligible to receive credits in a Health Account. You can also earn additional incentive credits when you participate in certain health and wellness activities.

The Health Account is legally considered a "health reimbursement arrangement," which allows you to pay for certain health care services on a before-tax basis using the credits you earn. This means that certain health care services can actually cost you less because you do not pay taxes on the expenses.

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation.

When you are enrolled in the HAP, the Company will contribute "credits" to a Health Account for you at the start of every year. You are also eligible to earn incentive credits for your Health Account each year by participating in a health screening and either testing tobacco-free or completing a Tobacco Cessation Program. The health screening and tobacco-free test are administered by Quest Diagnostics, a nationally accredited, independent health and wellness company. The Tobacco Cessation Program is administered by Personify Health.

The Health Account is part of the PG&E-sponsored medical plan for active employees, and you can only enroll in the PG&E-sponsored medical plan during very specific times — when you are first hired, when you enroll during Open Enrollment each year, or when you have an eligible mid-year change event (see "Mid-Year Election Change Events"). You are eligible for a Health Account when you enroll in the HAP, and your Health Account becomes automatically active once your account is credited.

The administrator for your Health Account will depend on whether you elected the Anthem HAP or the Kaiser HAP. If you elected the Anthem HAP, Optum Financial will administer your Health Account. If you elected the Kaiser HAP, Kaiser Health Payment Services will administer your Health Account.

If you have any questions about the Health Account, IRS rules, or your claims, you may contact your account administrator. Anthem members can call Optum Financial at **1-866-271-8144** or log on to Optum Financial at myPlans Connect by visiting mypgebenefits.com. Optum Financial Representatives are available from 7:30 a.m. to 5 p.m. Pacific time, Monday through Friday. Kaiser members can call Kaiser Health Payment Services at **1-877-750-3399** or visit Kaiser Permanente's website at kp.org/healthpayment. Kaiser Permanente representatives are available from 5 a.m. to 7 p.m. Pacific time, Monday through Friday.

You are not eligible for the Health Account if you are an intern, a contract or agency worker, or a hiring hall employee. Intermittent employees and other temporary employees are also not eligible for the Health Account.

Although the Health Account sounds similar to the Health Care Flexible Spending Account (HCFSA), it is a different type of benefit. For information on the HCFSA, see *Flexible Spending Accounts (FSAs)*.

Eligibility

If you are an active employee who is enrolled in the Health Account Plan (HAP), you are eligible to participate in the Health Account. If you terminate your HAP coverage as an active employee (for example, you leave the Company or drop coverage while still actively employed), you will no longer be eligible for the Health Account and will forfeit any balance remaining in the account, unless one of the following occur:

- You subsequently re-enroll in the HAP in the same calendar year, in which case your Health Account balance, if any, will be reinstated.
- You continue your HAP coverage through COBRA.
- You retire and are eligible for PG&E-sponsored retiree medical coverage (whether or not you actually enroll in a retiree medical plan).
- You go on Long-Term Disability (LTD) and remain enrolled in a PG&E-sponsored medical plan. You may keep and continue to use your unused credits for eligible expenses, but you will no longer receive any additional PG&E contributions nor annual incentives while on LTD.

When you enroll in HAP coverage through COBRA, you will keep any unused Health Account credit balance, and you also will be eligible to receive the annual Health Account credit allocation at the beginning of the plan year. However, you will not be eligible to earn incentive credits by taking the annual health screening and/or testing tobacco-free or completing the tobacco cessation program. For more information, please see "Continuing Coverage Under COBRA."

If you retire and are eligible for PG&E's retiree medical coverage, your Health Account balance will be transferred to a Retiree Health Account. For more information, please see "If You Retire."

If you go on Long-Term Disability, you will no longer be eligible for HAP coverage effective the first of the month following your LTD effective date. Therefore, you will need to switch to a different PG&E-sponsored medical plan. After going on LTD, you will be able to keep and use any unused credits in your Health Account provided that you're still enrolled in a PG&E-sponsored medical plan. However, you will not be eligible for the annual Health Account credit allocation at the beginning of each plan year, nor will you be able to earn incentive credits by taking the annual health screening and/or testing tobacco-free or completing the tobacco cessation program.

For more information, please see "If You Are on Long-Term Disability."

How the Health Account Works

The Company will automatically set up a Health Account for you when you enroll in the HAP and will deposit the annual Company credit allocation into your account. In addition, the Company will credit your account with incentive credit amounts if you complete a qualifying health activity (health screening or tobacco-free test/tobacco cessation program). It may take three to six weeks for a credit to be reflected in your Health Account.

Note that your Health Account is merely a recordkeeping account (also called a "notional" account). Incentive credits you earn will be credited to your Health Account, but the Health Account is not funded with cash. All reimbursements of eligible expenses are made from the Company's general assets. The account has no actual cash value that can be used elsewhere.

You may not contribute to the Health Account by making deposits to your Health Account through payroll deductions from your before-tax or after-tax pay.

For IRS purposes, the Company credits are not technically "paid" to you before going into the accounts, so they bypass all income tax withholding. Therefore, **federal income taxes, Social Security taxes, Medicare taxes and state income taxes are not withheld from any of these credits**, nor are any such taxes due when the money is used to pay for eligible expenses.

How to Earn Credits for Your Health Account

Your Health Account will be established when you enroll in the PG&E-sponsored HAP. When you're first hired and every January 1 after that, the Company credits your Health Account just for being enrolled in the HAP. As of January 1, 2026, this credit is $500 for single coverage and $1,000 for family coverage. If you move from single to family coverage midyear, you'll get the family level of credits.

You can also earn incentive credits, once a year, when you complete specific Health Account activities, as offered each year by the Company and as described below.

You must complete these Health Account activities by the end of the campaign year to earn incentive credits for that year. See mypgebenefits.com > Physical Health > Wellness Programs for incentive credit details and deadlines. Health Account activities completed in the fourth quarter will earn incentives for the next calendar year. Credits are not prorated if you enroll in the plan on a midyear basis. Any unused balances will roll over into the next calendar year as long as you remain enrolled in the HAP or otherwise qualify to keep the credits.

If your base rate of pay is lower than the qualifying threshold wage as of January 1 you'll get extra Health Account credits by the end of January. Visit mypgebenefits.com > Physical Health > Health Account for more details.

Dual Year Enrollment and Credits

If you were hired before August 1

You can earn Health Account credits for the year you were hired by taking the annual health screening and by testing tobacco-free or completing the telephonic tobacco cessation program, administered by Personify Health. You have until the end of August to complete these wellness activities to earn credits for the year you were hired.

If you were hired on or after August 1

You can earn Health Account credits for the year you were hired by taking the annual health screening and by testing tobacco-free or completing the telephonic tobacco cessation program, administered by Personify Health. You have until December 31 of the year you were hired to complete these wellness activities to earn credits for the year you were hired. If you complete these activities by December 31 of the year you were hired, you will have also earned the incentive credits for the following year. Credits for both calendar years will be deposited into your account in the next calendar year, but only if you enroll in the HAP for both the year of hire and the following year.

Health Screenings

You can take a health screening to earn an annual incentive credit of $250 for single coverage or $500 for family coverage. Your participation in the health screening earns credits for the entire family. Health screenings include a blood test for total cholesterol, HDL cholesterol, TC/HDL cholesterol ratio, LDL cholesterol, triglycerides and/or glucose, as well as tests for cotinine, blood pressure, height, weight, BMI and/or waist circumference. If you tested out of range for glucose or have a history of prediabetes or diabetes, you may be eligible for a hemoglobin A1C (HbA1c) test. You are not required to participate in the blood test or other medical examinations. You have a choice of four ways to complete a health screening:

- **At a local Quest Patient Service Center (PSC):** Schedule a PSC appointment at my.questforhealth.com. The fasting or non-fasting blood draw (2-3 vials) screening also includes a cotinine (tobacco) screening.
- **With a physician:** If you complete a health screening at your doctor's office within the campaign year (October 1 through August 31), you will need to download a Physician Results Form at my.questforhealth.com. The results form will have a look-back period of six months, which means your doctor must complete the form with results from a health screening that occurred on or after the April 1 prior to the beginning of the campaign year and then submit the form to Quest.
- **Onsite at a PG&E facility:** Specific locations and dates will be determined and communicated annually.
- **At home using a Self-Collection kit:** You can request a Self-Collection Kit at my.questforhealth.com. Follow the directions in your kit and return both Qcards to complete your fingerstick health screening and tobacco test.

If you are pregnant, you must contact Quest Diagnostics to obtain a Physician Affidavit Waiver Form to receive a pass for the screening. You must submit this form to your physician to complete and return to Quest Diagnostics. Once received, Quest Diagnostics will process and appropriately award your credit.

Health Account incentive credits will be based on participation, not on outcomes. The purpose of the health screening is to identify any potential health risks so you and your doctor can create a plan for making healthy choices that will lead to overall health improvements. Identifying data, such as your individual results, will not be shared with PG&E. PG&E will only see de-identified summary health screening data in an effort to understand overall health trends and areas that may need attention in PG&E's health and wellness programs. However, in order to receive the additional incentive credits into your Health Account, you must agree to release your personal results to Quest Diagnostics.

You are only eligible for one annual health screening credit each year.

Tobacco-Free Program

The health screening described above also includes a test to verify if you are tobacco-free. If you test tobacco-free, you will earn an annual $250 credit for single coverage or $500 for family coverage. If you do not test tobacco-free, you can complete Personify Health's free telephonic tobacco cessation program to earn the credit.

You will receive the credit after testing tobacco-free or completing four Personify Health telephonic tobacco cessation calls during the campaign year. You do not need to complete a health screening to participate in Personify Health's tobacco cessation program, but you do need to first enroll in the Personify Health Health and Wellness portal available on the web and as a free mobile app. For details, visit mypgebenefits.com > Physical Health > Wellness Programs > Health and Wellness Portal.

Note: It will be your responsibility to schedule your tobacco cessation appointments with Personify Health. Plan ahead and enroll early so that you have enough time to complete four calls by August 31 of the campaign year. Participants who enroll in the tobacco cessation program between August 1 and August 31 of the campaign year will have until December 31 to complete four calls to earn the tobacco-free credit. These participants will also receive tobacco-free credit for the following year if they enroll in the Health Account Plan. You're not limited to four calls; you can continue to use the program as long as you like.

The tobacco cessation program includes the following components:

- Setting a quit date
- Quit date preparation
- Identification of tobacco use triggers and coping strategies
- Individualized cessation plan
- Relapse prevention
- Risk-factor education
- Instruction on appropriate use of over-the-counter pharmacotherapy including nicotine replacement therapy (NRT) and availability of prescription medications to improve quit rates
- You may obtain up to two months of free nicotine replacement therapy (NRT) through the Personify Health tobacco cessation program.

You are only eligible for one annual tobacco-free incentive credit each year.

Request Process:

Alternative standards and waiver opportunities may apply for all similarly situated members. If you feel that it is unreasonably difficult to meet the program criteria to earn your incentive due to a medical condition or you would like to appeal your results due to a specific issue that prevents you from being able to meet the criteria as outlined, please call Quest at **1-866-271-8144** to initiate a request. Quest will work with you and your physician to certify the issue and, if applicable, develop another way for you to qualify for the incentive. For tobacco-use requests, you may request a cotinine challenge as an alternative.

Setting Up Your Health Account

Your Health Account is automatically set up once you enroll in the HAP. Once the account is credited, you can obtain reimbursements for eligible health care claims from the Health Account.

Logging on to Your Health Account for the First Time

- Anthem HAP members should go to the Benefits Portal to access your Health Account.
- Kaiser HAP members should go to kp.org/healthpayment. If you aren't already registered on kp.org, you'll be asked to create a new user ID, password, and security questions the first time you visit.

Once logged on, you can easily access your account balance, enter a new claim and view the reimbursement schedule. Your account balance is available at any time online, or over the phone.

For more information, contact your account administrator shown on the Benefits Portal, Optum Financial.

Reimbursement of Eligible Health Care Expenses

You can use the credits in your Health Account to "pay" for eligible health care expenses as defined by the IRS. When you obtain services that are eligible for reimbursement, you may "withdraw" the credits from your Health Account. Your use of these accounts is limited by the type of expenses you incur. (See *Flexible Spending Accounts (FSAs)* for more information.)

If you are covered under both the Health Care Flexible Spending Account (HCFSA) and the Health Account, money will be deducted first from your HCFSA and then from your Health Account. Unused funds in your Health Account will be rolled over in future years, as long as you remain enrolled in the HAP or otherwise eligible to keep the account. See "Eligibility" for information on account forfeitures.

Here are the ways you can pay for eligible health care expenses:

Automatic Reimbursement (for Kaiser members only)

If you are a Kaiser member:

- Any coinsurance or deductible liability that you have incurred will automatically be processed by Kaiser Health Payment Services; and
- If you have sufficient credits in your Health Account, Kaiser Health Payment Services will automatically pay your provider and you do not have to process any payments.

You can turn off this automatic payment feature any time in the calendar year. However, once turned off, it cannot be turned on again until the next calendar year. If you do turn off this feature, you will have to file manual claims. You must call Kaiser Health Payment Services at **1-877-750-3399** in order to turn off the automatic payment feature for each benefit plan year.

Use Your Health Care Debit Card

You'll automatically receive a Health Account Optum Financial health care debit card in the mail when you enroll in the Health Account. You'll receive a single card even if you're enrolled in more than one account (e.g., a HCFSA and a Health Account). A debit card is not available for the Dependent Care Flexible Spending Account (DCFSA).

If you are an Anthem member	If you are a Kaiser member
▪ Optum Financial will mail you an Optum health payment Mastercard. This card can be used for eligible medical, dental, and vision expenses, prescription drugs, and mental health and substance use disorder treatment. Your debit card is programmed to work only at providers whose primary business is to provide health care or health care products. ▪ Visit mypgebenefits.com > Financial Health > Spending Accounts for more information on eligible expenses.	▪ This card can be used for eligible medical, dental, and vision expenses, prescription drugs–including at Kaiser's pharmacy–and mental health and substance use disorder treatment. Your debit card is programmed to work only at providers whose primary business is to provide health care or health care products. ▪ Activate your card by following the instructions. ▪ Visit kp.org/healthpayment for more information on eligible expenses and locations where you can use your health care debit card.

The available balance on your card will reflect the current amount available in your Health Account. If your card is also associated with another account (e.g., Health Care FSA), the available balance on your card will reflect the total available for both accounts.

When you swipe your debit card, the system makes sure that your account is active and that you have sufficient funds for the full amount. If not, the transaction will be denied. As an alternative, you can swipe the card for the amount left in your account and pay the difference with another form of payment, or you can pay out of your pocket and file a claim for reimbursement.

Be sure to keep your itemized receipts as documentation. Although your health care debit card eliminates the need to file paper claims for prescription drugs and medical supplies, your charges must be verified. **Always keep**

your receipts for tax purposes, in case Optum Financial or Kaiser Health Payment Services needs a receipt, or the IRS requests them to confirm a purchase. Optum Financial or Kaiser Health Payment Services will generally notify you within approximately a week from the date of your health care debit card swipe if a receipt is needed. If Optum Financial or Kaiser Health Payment Services has your email information, notification will be electronic. Otherwise, it will be by mail.

If you use the health care debit card for an ineligible expense or for one on which Optum Financial or Kaiser Health Payment Services does not receive proper documentation, you will be required to reimburse the account for the amount of that transaction.

Be sure to verify your expenses: Optum and Kaiser will send multiple reminders if you need to verify expenses. You'll have 180 days to verify your expenses. After 180 days, if you haven't verified expenses and they total more than $150, your health payment card will be suspended per IRS rules.

If you need to order a replacement or additional health care debit card, you can log on to your online account or call Optum Financial at **1-866-271-8144** or Kaiser Health Payment Services at **1-877-750-3399** to request another card. Be sure to call as well if your card is lost or stolen.

More details on how to use your health care debit card and how to submit expenses are available by contacting your card administrator. If you are an Anthem member, call Optum Financial at 1-866-271-8144 or visit Optum Financial.com. If you are a Kaiser member, call Kaiser Health Payment Services at **1-877-750-3399** or visit kp.org/healthpayment.

Pay for the Expense and File a Claim

You can also pay for out-of-pocket expenses using your own personal credit or debit card, cash or check, and keep your itemized receipt as documentation. Then, log in to your online account to file for reimbursement. For Kaiser members, this option applies when you:

- have opted out of the Automatic Reimbursement feature;
- are paying for services not covered under the HAP; or
- have depleted the funds in your Health Account before your current incentive credits have been earned.

Here's how the online or paper claim processing works:

1. **You may pay for the expense**, although it is not necessary to pay the expense prior to submitting your claim for reimbursement. Nevertheless, you are responsible for paying all invoices on time, regardless of when you receive your reimbursement. If Optum Financial or Kaiser asks you to verify an expense on your card, you'll need to submit an Explanation of Benefits (EOB) or itemized receipt.
2. **If a portion of a health care expense is covered by any insurance for which you are eligible, file a claim under that plan first.** You should receive an Explanation of Benefits (EOB) or similar statement showing how much the plan paid, if anything. If you do not receive one, contact the claims administrator or insurance company and request one. You also may submit an itemized print-out from your health plan's website.
3. **Then, log in to your account** by going to Optum Financial.com and selecting the log-in link if you are an Anthem member, or to kp.org/healthpayment and entering your user ID and password if you are a Kaiser member. Follow the prompts to file a claim.

If you need help determining which of your expenses are eligible, you should contact Optum Financial or Kaiser Health Payment Services. Eligibility for reimbursement is based on when services are actually received, regardless of when you pay for such expenses.

Print and mail the completed claim submission form, along with original invoices, receipts, Explanations of Benefits (EOBs), or health plan website claims print-outs to:

If you are an Anthem member	If you are a Kaiser member
Optum Financial Claims Department P.O. Box 622317 Orlando, FL 32862-2317	Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540

Be sure to keep a photocopy of everything for yourself before you submit it to the Optum Financial or Kaiser Health Payment Services processing center. Or you may fax your completed claims submission form and a copy of the original invoices to 1-877-353-9236 if you are an Anthem member or 1-877-535-0821 if you are a Kaiser member. Save a copy of your fax confirmation receipt as proof of successful submission.

Processing of Manual Claims

Claims are processed daily. Once your claim is processed, you'll receive a reimbursement check mailed to your home. Or you can sign up for direct deposit into your bank account at OptumFinancial.com if you are an Anthem member or kp.org/healthpayment if you are a Kaiser member. If you choose automatic bank account deposits for your Health Account in any calendar year, the election will automatically roll over when you re-enroll in the Plan for a future year.

How to Avoid Overpayment

When you pay for health care expenses at the doctor, pharmacist, hospital, dentist, or eye doctor, always present your health insurance ID card first to ensure your claims are filed correctly.

Except for pharmacy purchases, if your health care provider asks you to pay at the time of service, don't pay right away. Instead, wait until your claim is processed and you receive your Explanation of Benefits (EOB). This helps avoid overpayment. Compare your EOB with the provider bill to verify the amount being charged by your provider is the same as the patient balance on the EOB. You then may use the free Optum Financial app to use the Pay Provider feature to send money to your provider for the amounts not paid by your health plan. Alternatively, you may pay using your health care debit card if enough funds are available to pay the expense, or you may use your own personal credit/debit card, cash or check and then request reimbursement from your Health Account.

How to Handle Claim Adjustments (for Optum Financial Members Only)

"Positive adjustment" is when you owe more money than what you initially paid with your health care debit card. If funds are available, you may use your health care debit card to satisfy the amount or pay your health care provider out of pocket and submit a claim to Optum Financial for reimbursement.

For example, you went to the doctor and you were asked to pay $25 with your health care debit card. Once you received your doctor's bill and Explanation of Benefits (EOB) from your health plan, you were informed that you owed an additional $10. At this point, you can either use your health care debit card to pay for the additional $10 or pay out of pocket and then submit a claim to Optum Financial for reimbursement.

"Negative adjustment" is when you overpay your health care provider. If you receive an EOB or billing statement indicating you owe less or are due a credit after using your health care debit card to pay your health care provider, you will need to contact your provider to receive a refund and then reimburse your Health Account for the excess payment made or provide a receipt for a different expense that qualifies for reimbursement. For example, you went to the doctor and you were asked to pay $25 with your health care debit card. Once you received your doctor's bill and EOB from your health plan, you were informed that you were only responsible for $15 instead of $25. At this point, you should contact your provider and request a refund for the amount you overpaid. Then, you'll need to resolve the overpayment from your Health Account in one of the following ways:

1. **Submit substitute receipts for other eligible expenses you have incurred but which have not yet been paid by Optum Financial**. Make sure the substitute expenses you submit are equal to or greater than the excess amount paid to the provider.

2. **Repay Optum Financial for the excess amount.** You can pay your Health Account back online at Optum Financial.com or by sending a personal check for the excess amount, payable to Optum Financial, at:

   Claims Department
   P.O. Box 622317
   Orlando, FL 32862-2317

Always Save Your Itemized Receipts

Always save your itemized receipts regardless of how you pay. You're responsible for ensuring your withdrawals are for IRS-approved expenses. You'll need your receipts to verify your expenses were eligible if you're ever audited. The IRS may require documentation to show the money was used for qualified expenses. Be sure your receipts have all of these details:

- Date of service or purchase
- Name of patient
- Name and address of the provider or merchant
- Description of the service provided or product purchased
- Amount paid

Health care debit card or credit card receipts, non-itemized cash register receipts, and canceled checks are insufficient. Please be sure you have a doctor's prescription for any over-the-counter medicines you purchase, as the eligibility of over-the-counter items depends on whether you have a prescription. For information on eligible expenses, visit OptumFinancial.com if you are an Anthem member or kp.org/healthpayment if you are a Kaiser member.

If requested by Optum Financial or Kaiser Health Payment Services, please be sure to provide your health care debit card receipts within the time frame requested. Otherwise, your payment or swipe transaction will be deemed ineligible and you will be required to refund the amount of transaction.

Availability of Health Account Credits for Reimbursement

For Health Account claims, you must first be enrolled in the Health Account Plan (HAP) in order for your Health Account to be established and for claims to be reimbursed.

The amount of the reimbursement will depend upon how much money is available in your Health Account and other accounts (e.g., Health Care FSA or HCFSA), if applicable. You will be reimbursed in full for your eligible expenses, provided your (combined) account balance that can be used to pay such eligible expenses is equal to or greater than the amount of your claim. If your (combined) account balance that can be used to pay such eligible expenses is less than the amount of your claim, you will receive partial reimbursement for your claim. If you are covered under both the HCFSA and the Health Account, claims will first be paid from your HCFSA.

At the end of each year, any remaining credits in your Health Account will automatically roll forward to the next calendar year, provided you remain enrolled in the HAP or you are otherwise eligible to keep the account. However, if you terminate your HAP coverage as an active employee (for example, you leave the Company or drop coverage while still actively employed), you will no longer be eligible for the Health Account and will forfeit any balance remaining in the account, unless one of the following occurs:

- You subsequently re-enroll in the HAP in the same calendar year, in which case your Health Account balance, if any, will be reinstated.
- You continue your HAP coverage through COBRA.
- You retire and are eligible for PG&E-sponsored retiree medical coverage (whether or not you actually enroll in a retiree medical plan).
- You go on Long-Term Disability and remain enrolled in a PG&E-sponsored medical plan.

If your Health Account eligibility ends because you are no longer enrolled in the HAP and none of the above exceptions apply, you will be able to submit Health Account claims for any eligible health care expenses incurred

prior to the date on which your Health Account coverage ended. Claims for eligible expenses must be submitted to your Health Account Administrator no later than 90 days after the date on which your HAP/Health Account coverage ends.

To continue in the HAP after you terminate employment, see "Continuing Coverage Under COBRA."

Different rules apply for funds remaining in a HCFSA at the end of a calendar year. A portion of your remaining HCFSA can be rolled over to the next calendar year. See *Flexible Spending Accounts (FSAs)* for full details.

Additional Health Account Credits for Financial Hardship

You may petition to receive additional credits for your Health Account due to a financial hardship. If the petition is granted, you will receive a one-time credit of $1,000 in your Health Account if you have single coverage and a $2,000 credit if you have family coverage. These credits must only be spent on medical expenses that are covered under the HAP. If you have outstanding medical claims at the time of the petition, the claims can be paid through additional Health Account funds.

To be eligible for this provision, you must have reached the out-of-pocket maximum for a minimum of two years in a row. You may be eligible to petition once every two years provided you have reached the out-of-pocket maximum in each of the previous two years. Each petition will be considered separately.

Participants may petition the Company to request additional Health Account credits based on hardship appeal only if they can demonstrate immediate and heavy financial need. Your request, submitted in writing, must describe your financial hardship and provide satisfactory proof of valid hardship.

In reviewing your petition, the Company will look for:

1. a summary of the financial hardship conditions,
2. the total cost of the medical bills supported by an Explanation of Benefits (EOB),
3. the amount of additional PG&E contributions requested (which should not exceed the amount listed in (2) or the maximum allowed amount),
4. an agreement to keep source documents to support the request, and provide copies of them, upon request, to PG&E, and
5. your certification that the information provided is true and accurate.

You'll also need to authorize disclosure of any PHI in the information being provided in accordance with HIPAA to PG&E employees as necessary to process the request, including:

1. an explanation that, in making the request, you are authorizing disclosure of PHI to PG&E employees as necessary to review and make a determination of the request,
2. a description of the PHI being disclosed (i.e., proof of medical expenses incurred),
3. that the authorization will expire upon the final determination of the request,
4. notice of the right to revoke the authorization in writing, prior to expiration, and
5. a signature and date line.

For additional information or support, contact benefits@pge.com.

You must submit your petition for additional credits in writing to:

Pacific Gas and Electric Company
Benefits Department – Appeals
300 Lakeside Drive
Oakland, CA 94612

Within 60 calendar days of the date on which the petition is received, you will receive a written response. There may be special circumstances where an extension of up to an additional 90 calendar days may be required. You will be notified if such an issue occurs. If the Benefit Department denies your petition, you will receive a written

response that will include the reason for the denial and an explanation of additional appeals procedure. You may then have the denial reviewed by the Employee Benefits Appeals Committee (EBAC). You must submit an appeal in writing stating the reasons for the appeal and enclosing all relevant documentation and information that supports the appeal. You will receive the EBAC's decision within 90 calendar days of the EBAC's receipt of the appeal unless there are special circumstances where an extension of up to an additional 90 calendar days may be required.

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

- the specific reason(s) for the denial of the claim;
- a reference to the specific Plan provision(s) on which the denial is based; and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under section 502(a) of ERISA.

The decision to grant or deny the funding is non-grievable.

Additional Health Credits

Employees whose base pay rate is below a qualifying threshold wage as of January 1 will automatically receive an extra $500 credit in your Health Account by the end of January. If you get a raise after receiving the additional credit, you can still keep the extra $500 in your Health Account. New employees who join the plan after January 1, whose base rate is equal to or less than the qualifying threshold wage will receive the additional $500 credit in their Health Account during the calendar year. The qualifying threshold wage may change from year to year. For details, visit mypgebenefits.com > Physical Health > Health Account Plan and Health Account. Contact Quest at **1-866-271-8144** or email **wellness@questdiagnostics.com** if you have questions about the additional funding.

What's Eligible and What's Not

Health Account Eligible Expenses

You can use your Health Account to pay for eligible tax-deductible health care expenses for yourself and your eligible dependents. However, your dependents must be enrolled in your Company-sponsored medical plan coverage in order for their eligible expenses to be reimbursable.

You can use your Health Account to pay for Qualifying Health Care Expenses. These are expenses incurred by you, or by your dependent while the dependent is enrolled in the Health Account Plan, for medical care as defined in Internal Revenue Code sections 213(d) or 106(f). Qualifying Health Care Expenses do not include expenses that are reimbursed or otherwise covered by a medical plan, medical insurance, or otherwise, nor do they include health insurance premiums or premiums for long-term care insurance or long-term care services.

"Eligible Dependents" Defined

Your eligible dependents are individuals who qualify as your tax dependents under Internal Revenue Code section 105(b). Many registered domestic partners do not qualify as your tax dependents for this purpose.

For purposes of Health Account claims, your dependents must be enrolled in your PG&E-sponsored medical plan coverage in order for their eligible health care expenses to be reimbursable by Health Account credits.

Many health care expenses not covered or not paid in full by a health care plan, including deductibles, copayments, coinsurance or other out-of-pocket expenses, such as for prescription drugs and out-of-network services, are eligible expenses. To be eligible, the expense must be incurred during the period in which you are enrolled in Company-sponsored medical plan coverage. If you enroll in the HAP mid-year, for example, expenses incurred before you were enrolled are not eligible for reimbursement. Likewise, if you do not continue enrollment in the HAP, expenses for health care services received during the period when you were not enrolled in the HAP are not eligible for reimbursement.

For more information, refer to Anthem's list of eligible expenses, and Kaiser's list of eligible expenses on mypgebenefits.com. Contact your Health Account administrator or tax advisor if you need further information about which expenses are reimbursable.

Ineligible Expenses

You cannot use your Health Account credits for any expenses that are paid for by any other medical, dental or vision plans, not considered tax-deductible by the IRS, or not considered an eligible health care item.

Partial Prepayments

Many medical treatment programs span several plan years. For example, orthodontia programs may take two or more years. Reimbursement of the entire expense "up-front" violates the "expense incurred" requirement. In the case of orthodontics, the orthodontist allocates service expenses over the course of the treatment plan. Payments you make for treatment received in the current calendar year are eligible for reimbursement from your account for the same calendar year. If you are an Anthem HAP member and you have questions about how claims for ongoing treatment programs will be reimbursed, contact Optum Financial at **1-866-271-8144** or log on to Optum Financial.com; if you are a Kaiser HAP member and have questions, contact Kaiser Health Payment Services at **1-877-750-3399** or log on to **kp.org/healthpayment.**

If Eligibility Is Denied

For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Care Plan for Active Employees, see the *Health Care Participation*.

Health Account Claims and Appeals

Claims

If a Health Account claim you submit is denied in part or whole, Optum Financial or Kaiser Health Payment Services, as the third-party Claims Administrator, will provide you with written notice within 30 days of receiving your claim. In certain cases, an additional 15 days may be required by your Claims Administrator to respond to you. If an extension is required, you will be notified of this extension within the initial 30 days from the date of the Claims Administrators receipt of your claim.

Send your claims to:

If you are an Anthem member	If you are a Kaiser member
Optum Financial Claims Department P.O. Box 622317 Orlando, FL 32862-2317	Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540

If Optum Financial or Kaiser Health Payment Services needs additional information from you, you'll be given 45 days from the receipt of this notice to provide the additional information. In this case, the third-party Claims Administrator will respond in writing within 15 days after receiving your additional information.

See "Claims and Appeals — Medical Benefits" for the information that will be included in the denial notice.

Appeals

If you believe this initial determination results in the denial of a Health Account benefit to which you may be entitled, you may appeal to the Plan Administrator.

Send your appeal to:

If you are an Anthem member	If you are a Kaiser member
Optum Financial Claims Department P.O. Box 622317 Orlando, FL 32862-2317	Kaiser Health Payment Services c/o Health Account P.O. Box 1540 Fargo, ND 58107-1540

This appeal must be made in writing within 180 days after receiving written notice of the denial from Optum Financial if you are an Anthem member or from Kaiser Health Payment Services if you are a Kaiser member, and must contain the following information:

- the reason(s) for making the appeal;
- the facts supporting the appeal;
- the amount claimed; and
- the name and address of the person filing the appeal (claimant).

To expedite processing, you should also include an AUTHORIZATION TO USE AND/OR DISCLOSE PERSONAL HEALTH INFORMATION form. You can access a copy online at mypgebenefits.com (select > Resources > Legal Notices), or by calling the PG&E Benefits Service Center at 1-866-271-8144.

Optum Financial or Kaiser Health Payment Services will generally make a decision within 60 days after receiving the appeal and mail or email a copy of the decision to you promptly (non-receipt of the authorization form may delay your appeal). See "Claims and Appeals — Medical Benefits" for the information that will be included in the denial notice.

Questions About Claims for Reimbursement

You should refer any questions about your claims for reimbursement to your Claims Administrator at the following address and phone numbers.

If you are covered by Optum Financial:

Optum Financial
Claims Department
P.O. Box 622317
Orlando, FL 32862-2317

1-866-271-8144

If you are covered by Kaiser:

Kaiser Foundation Health Plan Inc. SF
c/o Health Payment Services
P.O. Box 1540
Fargo, ND 58107-1540

1-877-750-3399

PG&E's Voluntary Claims and Appeals Review Process

If you are not satisfied with the claims and appeals review process completed with Optum Financial or Kaiser Health Payment Services, as applicable, you may elect to use PG&E's Voluntary Claims and Appeal Review Process. You have 90 days from the date of receipt of the final decision from Optum Financial or Kaiser Health Payment Services to elect this claims and appeals review process.

The first step of the Voluntary Claims and Appeals Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include an AUTHORIZATION TO USE AND/OR DISCLOSE PERSONAL HEALTH

INFORMATION form. You can access a copy online at mypgebenefits.com (select > Resources > Legal Notices) or by calling the PG&E Benefits Service Center at **1-866-271-8144**.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
Appeals
300 Lakeside Drive
Oakland, CA 94612

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the Authorization form may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

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

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

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

- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under section 502(a) of ERISA.

Using this voluntary process does not restrict your ability to file suit.

More About the Accounts

Account Limitations

The various accounts are governed by IRS regulations. You should keep in mind these regulations and limitations:

- If you have a Health Account, Health Care Flexible Spending Account (HCFSA) and/or a Dependent Care Flexible Spending Account (DCFSA), you cannot transfer money between any of the accounts.
- All of the money in your Health Account must be used to pay for expenses incurred after your account has been activated and credited by the Company with Health Account credits. Any unused money left in a Health Account after all expenses for the Plan Year have been submitted will be carried forward into the following year, unless you no longer qualify to keep the account, as described elsewhere in this section.

If You Have Both a Health Care Flexible Spending Account (HCFSA) and a Health Account

If you participate in both the HCFSA and the Health Account, your health care debit card, as well as the automatic reimbursement process (Kaiser members only), is programmed to deduct money first from your HCFSA to help you avoid forfeiting unused amounts at the end of the year. After you use all the money in your HCFSA, money will automatically then be drawn from your Health Account. Remember, only a portion from a HCFSA can be carried over each year, while balances in your Health Account roll over year after year, as long as one of the following occurs:

- You remain enrolled in the Health Account Plan (HAP), whether as an active employee or through COBRA;
- You retire with eligibility for PG&E's retiree medical coverage; or
- You go on Long-Term Disability and remain enrolled in a PG&E-sponsored medical plan.

Provision	HCFSA	Health Account
Types of eligible expenses you can incur	Eligible medical expenses incurred in the months in which you were covered under the HCFSA	Eligible medical expenses incurred during the months in which you were covered under the Health Account Plan (HAP)
When you can start incurring eligible expenses	▪ January 1 of the year for which you open the account, if you enroll during the Open Enrollment period ▪ The date your coverage is effective, if you enroll midyear	**The IRS prohibits you from filing claims for expenses you incur before your Health Account has been established.** You'll be able to incur eligible expenses on or after the date your Health Account is established, **not before**.
How you can pay for eligible expenses	▪ Automatic reimbursement process for Kaiser HAP members (unless you turn off the automatic reimbursement feature through Kaiser Health Payment Services) ▪ Your Optum Financial debit card (for Anthem HAP members) ▪ Your Kaiser debit card (for Kaiser HAP members): for pharmacy purchases only ▪ Your own personal credit card, cash or check ▫ You'll need to file a claim for reimbursement	

Provision	HCFSA	Health Account
Deadline for Filing Claim Reimbursements	▪ June 30 of the year following the plan year in which the claim was incurred ▪ Please note that full documentation (all applicable receipts and statements) must be received, along with the claim, by the deadline; otherwise, your claim will be denied.	▪ No deadline for submitting Health Account claims, as long as you remain enrolled in the HAP; claims can be submitted for prior years at any time. ▪ If HAP coverage ends, all outstanding claims incurred while a HAP participant must be filed within 90 days of the date on which HAP/Health Account coverage ends. ▪ Please note that full documentation (all applicable receipts and statements) must be received, along with your claim; otherwise, the claim will be denied until the appropriate documentation is received.

Deadline for Claim Reimbursements

Claims for eligible health care expenses can be submitted to the Health Account for reimbursement at any time, as long as you remain covered under the Health Account Plan (HAP). There is no annual filing deadline for claims incurred during each calendar year; claims incurred in prior calendar years can be filed in subsequent calendar years. However, if your HAP coverage ends, then all outstanding claims must be submitted to the processing center within 90 days of the date on which coverage ends. Any Health Account credits remaining after this date will be forfeited.

Please note that full documentation (all applicable receipts and statements) must be received, along with the claim, by the 90-day deadline. If complete documentation is not received by the deadline, then your claim will be denied.

If You Take a Leave of Absence Without Pay

If you take a leave of absence without pay and terminate your PG&E-sponsored medical plan coverage, you will no longer be eligible to participate in the Health Account because eligibility for the Health Account is tied to your enrollment in the Health Account Plan (HAP):

- If you return to work and are reinstated in the HAP in the same calendar year, your Health Account will also be reinstated with your previous credit balance (awarded credits less claims processed to date).
- If you do not return to work in the same calendar year, you will forfeit all funds accumulated in your Health Account. However, during the first 90 days following the end of your HAP/Health Account coverage, you will be able to submit claims for eligible expenses incurred *prior to* the date on which your coverage ended. Any Health Account credits remaining after this date will be forfeited, unless you return to work before the end of the calendar year, in which case your remaining credit balance will be reinstated (awarded credits less claims processed to date).
- If you return to work in a different calendar year, a new Health Account with a new credit allocation will be established if you re-enroll in the HAP, but the account will not contain any previously accumulated credit balance from the previous year.

For more information, please contact the PG&E Benefits Service Center at **1-866-271-8144**.

If You Are on Long-Term Disability

If you go on Long-Term Disability (LTD), you will no longer be eligible for HAP coverage effective the first of the month following your LTD effective date. Instead, you will be eligible to enroll in one of the PG&E-sponsored medical plans offered to employees on LTD (see *Medical Coverage for Participants on Long-Term Disability*). As an employee on LTD, you will be eligible to use any remaining credit balance in your Health Account until you exhaust it as long as you remain in a PG&E-sponsored medical plan. However, you will not be eligible to receive the annual Health Account credit allocation at the beginning of each plan year, nor will you be eligible to earn incentive credits by taking the annual health screening and/or testing tobacco-free or completing the tobacco cessation program.

If you return to active work in the same calendar year or a subsequent year and re-enroll in HAP coverage, you will receive the annual Health Account credit allocation at either the single or family level of coverage (provided you have not already received that year's credit allocation). You also will be eligible to earn incentive credits again by taking the annual health screening and/or testing tobacco-free or completing the tobacco cessation program.

For more information, please contact the PG&E Benefits Service Center at **1-866-271-8144**.

If You Leave the Company

If you leave the Company, you will no longer be eligible for the Health Account and will forfeit any balance in the account (unless you subsequently become a participant in the HAP again in the same calendar year, in which case your remaining Health Account balance (awarded credits less claims processed to date), if any, will be reinstated). You can continue your participation in the Health Account if you enroll in the HAP through COBRA (see "Continuing Coverage Under COBRA"). If you enroll in HAP coverage through COBRA, you will keep any unused account balance, and you will also be eligible to receive the annual Health Account credit allocation at the beginning of each plan year, while you are enrolled through COBRA. However, you will not be eligible to earn extra credits for taking the annual health screening and/or testing tobacco-free or completing the tobacco cessation program.

If participation is not continued through COBRA, your eligibility will stop at the end of the month in which you leave the Company.

You can submit claims for reimbursement from the Health Account for eligible expenses incurred during the months in which you were enrolled in the HAP. Claims must be submitted to the processing center within 90 days of the date on which your HAP/Health Account participation ends. Any credits remaining in the account after this will be forfeited (unless you enroll for the HAP through COBRA). For example, if you resign on April 15 and do not enroll in the HAP through COBRA, your Health Account participation ends on the last day of the month, or April 30. Claims must be filed within 90 days of April 30, which is July 29. Any Health Account credits remaining after this date will be forfeited.

For more information, please contact the PG&E Benefits Service Center at **1-866-271-8144**.

If You Retire

If you retire and are eligible for PG&E-sponsored retiree medical coverage – even if you waive retiree medical coverage when you first retire – any unused Health Account credits you have remaining at retirement will be transferred to a Retiree Health Account, which the Company will set up for your use during retirement. You can use these Retiree Health Account credits to pay for eligible health care expenses you incur after retiring, including post-tax insurance premiums you pay for medical, dental and vision coverage. However, you won't receive any new credit allocations to your Retiree Health Account after you retire, because eligibility for the annual Health Account credit allocations is tied to enrollment in the HAP, and the HAP is not available to retirees.

For more information, please contact the PG&E Benefits Service Center at **1-866-271-8144**.

If You Are Re-Hired by the Company

Any credits remaining in your Health Account 90 days after the date on which your HAP/Health Account participation ends will be forfeited, unless you enroll in the HAP through COBRA or you are eligible for PG&E-

sponsored retiree medical coverage. However, if you leave the Company and are later re-hired by the Company in the same calendar year, your previous Health Account balance (awarded credits less claims processed to date), if any, will be reinstated.

Dental Coverage

The Company offers dental coverage that emphasizes the value of diagnostic and preventive care, while also paying a significant portion of more expensive care when dental work is needed.

Dental coverage is administered by Delta Dental of California. The Plan provides coverage worldwide and allows you to receive care from any licensed dentist. You may seek services from one of the many dentists who belong to the Delta Dentist Network, or you may go to a non-participating dentist.

Eligibility and Enrollment

For information on participating in dental coverage, see *Health Care Participation*.

Dental Coverage at a Glance

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

The following chart summarizes what the Plan will reimburse you for covered services. **All benefits are subject to Delta Dental's maximum contract allowances.**

Provisions	Coverage
Choice of Dentist	Any; for maximum benefits, use a PPO or Premier Dentist
Annual Deductible*	Delta Dental PPO Network ▪ $25/person and $75/family Delta Dental Premier Network or Non-Participating Dentist ▪ $50/person and $150/family For all covered services except as provided below
Diagnostic and Preventive Care	No deductible You pay 15% of eligible preventive care, including: ▪ Two exams/year ▪ Full-mouth X-rays or Panorex films once every five years ▪ Bitewing X-rays twice/year for dependents up to age 18; once/year for adults age 18 and older ▪ Two cleanings/year ▪ Fluoride treatments ▪ Space maintainers
Basic Care	Deductible required You pay 15% of eligible basic care, including: ▪ Fillings ▪ Root canals ▪ Extractions ▪ Oral surgery ▪ Treatment of the gums (periodontia) ▪ Sealants for eligible dependents under age 16: (permanent first molars through age eight; second molars through age 15)

Provisions	Coverage
Major Care	Deducible required You pay 15% of eligible major care, including: ▪ Crowns ▪ Inlays ▪ Onlays ▪ Cast restorations ▪ Bridges ▪ Implants ▪ Cone Beam CT once per 12-month period
Annual Maximum	$2,500/person (excludes orthodontia)
Orthodontia Benefit	You pay 50% of covered expenses; lifetime maximum benefit of $2,000/person

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

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

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

How Dental Coverage Works

The Dental Plan is a fee-for-service plan. In other words, the Plan reimburses your covered expenses at a specified percentage after you pay any applicable deductible. You may seek services from one of the many dentists who participate in the Delta Dental PPO Network or Delta Dental Premier Network, or from a non-participating dentist.

A feature of Delta Dental of California is the availability of a network of dentists. Approximately 93% of California dentists participate in the Delta Dental Premier Network. Delta Dental also has another network called the Delta Dental PPO Network that has fewer dentists, but many of the same dentists also participate in the Delta Dental Premier Network. Dentists in both networks file their fees with Delta Dental and agree to accept them as payment in full (these fees are called "Delta Dental's maximum contract allowances"). You may receive treatment from any licensed dentist. However, there are three advantages to receiving treatment from a dentist in either the Delta Dental PPO Network or the Delta Dental Premier Network:

- Delta Dental pays Delta dentists directly, so there are no claim forms to submit, and you do not have to pay the claims expense upfront.
- The Dental Plan features agreed-upon fees for Delta Dentists, so you won't be responsible for any excess charges above your normal deductible and coinsurance for allowed services.
- You usually save money if you use a dentist that participates with Delta Dental, since Delta generally allows a higher reimbursement base for participating dentists.

When services are provided by a Delta Dental PPO dentist, there is an annual deductible of $25 per person or $75 per family. When services are provided by a Delta Dental Premier Network dentist or a non-participating dentist, there is an annual deductible of $50 per person or $150 per family. You may seek services from dentists in both networks during a calendar year, but once services are rendered by a Delta Dental Premier dentist or a non-participating dentist, the annual deductible will "pop up" to the $50 per person/$150 per family for the rest of the year. The deductibles are coordinated between the Delta Dental PPO and the Delta Dental Premier

Network. For example, if you have met the $25 individual annual Delta Dental PPO deductible and then seek services with a Delta Dental Premier Network dentist, the $25 will go towards the $50 individual annual deductible.

If you would like a list of either of the two Delta networks of dentists, call Delta Dental at **1-888-217-5323** or check its website at **deltadentalins.com/PG&E.**

Non-Participating Dentists

If you receive treatment from a non-participating dentist, you will have to pay the dentist yourself, and then file a claim with Delta Dental for reimbursement. Please be advised that the methodology Delta uses for reimbursing non-participating dentists often results in larger out-of-pocket costs for you. When services are provided to you by a non-participating dentist, there is an annual deductible of $50 per person and $150 per family and your reimbursement from Delta Dental is based on the prevailing fee. The prevailing fee is the applicable percentage of the lesser of the fee charged or the fee which satisfies the majority of Delta Dental Plan of California's Participating Dentists for a single procedure as determined by Delta Dental of California. You will be responsible for any expenses that exceed the reimbursement by Delta Dental. Covered expenses reimbursable to you are determined by Delta Dental. Additionally, you are responsible for paying any expenses not covered by Delta Dental, including any applicable deductible and coinsurance.

Predetermination of Costs

If your dentist (whether or not he or she participates in one of Delta's networks) recommends extensive dental work ($300 or more), you should have your dentist file a "Predetermination" with Delta Dental before the work begins. Delta Dental will provide a predetermination claim notice to both you and your dentist, advising ahead of time whether the proposed treatment is a covered benefit and, if so, how much Delta Dental will pay as well as what your share of the costs will be.

Predetermination of costs does not guarantee payment. It is only an estimate of the amount Delta Dental will pay if you continue to be eligible and meet all the requirements of the Dental Plan at the time the treatment you have planned is completed. If you receive other covered services after receiving a predetermination of costs, Delta Dental will still only pay for covered services up to the $2,500 annual maximum.

The Dental Plan does not cover all services your dentist may deem necessary or appropriate. For instance, while your dentist may recommend three cleanings a year, the Plan covers a total of only two cleanings during a calendar year. Any cleanings provided during periodontal procedures are counted as part of this annual limit.

What's Covered

The Dental Plan provides benefits for diagnostic and preventive care, basic and major care, and orthodontia.

- Diagnostic and Preventive Care — Includes exams and X-rays (and/or Panorex films), cleanings, fluoride treatments and space maintainers.
- Basic Care — Includes fillings, extractions, oral surgery, treatment of the gums (periodontal) and root canals using standard procedures as determined by Delta Dental. Basic Care also includes sealants for eligible dependents under age 16 (permanent first molars through age eight and second molars through age 15) using standard procedures as determined by Delta Dental.
- Major Care — Includes implants, crowns, inlays, onlays, cast restorations and bridges fabricated by using accepted conventional procedures and materials as determined by Delta Dental.
- Orthodontia — Includes braces and retainers to straighten teeth.

Dental Plan

If you use a participating Delta dentist, the Dental Plan pays 85% of covered expenses for Diagnostic and Preventive Care with no deductible. This includes two routine check-ups and two cleanings (including procedures

that contain cleanings, such as periodontal maintenance cleaning) for each covered family member in any calendar year, plus periodontal X-rays and fluoride treatments. (See "Plan Limitations.")

If further dental care is needed and you see a Delta Dental Premier Network dentist or a non-participating dentist, you pay the first $50 as your annual individual deductible or $150 as your maximum family deductible. The network the dentist belongs to will determine the deductible amount. If you only seek care from Delta Dental PPO dentists, you will be responsible for a $25 annual deductible, up to a family maximum deductible of $75. If at any time during the year you seek care from a Delta Dental Premier Network or non-participating dentist, your annual deductible will be $50 per person, up to a family maximum deductible of $150.

The Dental Plan pays 85% of covered expenses for Basic Care, such as fillings, and 85% for extractions, oral surgery and treatment of the gums (periodontal maintenance cleanings, deep cleanings and gum surgery). For Major Care covered expenses, such as crowns and implants, the Plan also pays 85%. You pay the rest as your coinsurance. If you use a non-participating dentist, you may be responsible for more than your coinsurance and deductible. The Dental Plan pays up to $2,500 in dental benefits each year for each covered member of your family.

Orthodontic Benefits

For orthodontic services, 50% of the total cost of expenses (not subject to deductible) – up to a lifetime maximum of $2,000 per covered family member – is covered by Delta. The 50% orthodontia benefit is paid in two installments. The first installment will be made for 25% of the cost of the approved treatment plan, after deductible. The remaining 25% (subject to the lifetime cap) will be paid 12 months later. As noted here, calculations of orthodontic benefits are based on 50% of the total treatment plan amount subject to the lifetime orthodontic maximum of $2,000 for each covered family member.

Plan Limitations

Benefits for the following services are limited as summarized below. Please note that if you exceed the Plan limits, you will be responsible for payment for services beyond the limits. For instance, your dentist may recommend more than two cleanings per year. While more cleanings may be advisable, the Plan will only cover the cost for two annual cleanings. You will be responsible for the cost of additional cleanings.

Diagnostic and Preventive Benefits

- Oral Examinations — Benefits are limited to two oral exams in a calendar year (January through December), while you are eligible under any Delta Dental plan.
- Prophylaxis (cleanings) — Cleanings (including procedures that contain cleanings, such as periodontal maintenance cleaning) and fluoride treatments are covered only twice in a calendar year, while you are eligible under any Delta Dental plan.
- Full Mouth X-rays — Complete mouth X-rays or Panorex films are covered only once every five years while you are eligible under any Delta Dental plan, unless your dentist shows a special need for an increased frequency and submits documentation to and receives authorization from Delta Dental. (Panorex films may be covered even if you receive a full-mouth X-ray.)
- Supplementary Bitewing X-rays — Supplementary bitewing X-rays are covered only:
  - Twice in a calendar year for Eligible dependents up to age 18, while they are eligible under any Delta Dental plan, or
  - Once a calendar year for adults age 18 and over, while they are eligible under any Delta Dental plan.

If you or your dentist needs to reschedule an appointment, it is your responsibility to ensure the rescheduled appointment still meets the timing limitations of the Dental Plan in order to receive applicable benefits.

Basic Care Benefits

- Periodontal Procedures — Limited to two in a calendar year. If such procedures include prophylaxis (cleanings, including procedures that contain cleanings, such as periodontal maintenance cleanings), those cleanings are counted towards the annual limit.
- Sealants — Pit and fissure sealants are limited to Eligible dependents under age 16 (permanent first molars through age eight and second molars through age 15) using standard procedures as determined by Delta Dental. Sealant benefits include the application of sealants only to permanent posterior molar teeth with no decay, with no restorations and with occlusal surface intact. Sealant benefits do not include the repair or replacement of a sealant on any tooth within two years (24 months) of its application.

Major Care Benefits

- Crowns, Inlays, Onlays and Cast Restorations — If you receive any such restoration while a member of a Company-sponsored Dental Plan or any other plan provided through Delta Dental, a restoration for the same tooth can only be replaced after five years, unless Delta determines that replacement is required because the restoration is unsatisfactory, or the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.
- Prosthodontic Benefits — The Dental Plan will pay the applicable percentage of the dentist's filed fee for standard cast chrome or acrylic complete or partial dentures (removable prosthetic appliances provided to replace missing natural, permanent teeth which are constructed using accepted conventional procedures and materials). Benefits for prosthodontic appliances are paid by Delta only once every five years, unless Delta determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta plan will be made if it is unsatisfactory and cannot be made satisfactory.
- Implants — For implants (materials implanted into or on bone or soft tissue) or the removal of implants, you pay 15% (subject to the annual maximum benefit of $2,500). What is covered for implants includes the placement of the implant, abutment, and prosthetic device. Before work begins, you should have your dentist file a "Predetermination" with Delta Dental to review whether the proposed treatment is a covered benefit.
- Cone Beam CT -Cone Beam CT capture and interpretation are covered not more than once in any 12 month period. Interpretation of a diagnostic image only is covered for cone beam services. Cone beam interpretation is a covered Benefit when provided by a different Dentist/Dentist office than the Dentist/Dentist office who provided the cone beam capture only services.

Orthodontic Benefits

- Covered expenses for Delta Dentists are limited to the lesser of Delta Dental's maximum contract allowances or the fee actually charged.
- Orthodontic services which are begun before a member's coverage date are not covered.
- Periodic payments for orthodontics paid by the Dental Plan shall terminate on the next payment due date after the earliest of the following:
  - the date the employee's participation in the Dental Plan terminates;
  - the first day of the month following the month in which a dependent ceases to meet the definition of a dependent as stated in the Dental Plan;
  - the date treatment is terminated for any reason prior to completion of the treatment plan; or
  - the date the Dental Plan terminates.
- Repair or replacement of an orthodontic appliance furnished in whole or in part is not covered.
- X-rays and extraction procedures related to orthodontics are not covered under orthodontic benefits, but may be covered under other benefits as stated in the Dental Plan.

Other Limitations

- Alternative Treatment — If you choose an alternative treatment that costs more than Delta Dental's maximum contract allowance of the standard treatment, you will be responsible for the difference in cost in addition to your annual deductible and appropriate coinsurance.

What's Not Covered

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

- Services covered under Workers' Compensation or employers' liability laws.
- Services provided by any government agency.
- Services or supplies that are not covered expenses, as determined by Delta Dental.
- Charges in excess of Delta Dental's maximum contract allowances, the prevailing fee or the filed fee, as determined by Delta Dental. (The prevailing fee is the applicable percentage of the lesser of the fee charged or the fee which satisfies the majority of Delta Dental Plan of California's Participating Dentists for a single procedure, as determined by Delta Dental of California.)
- Services and supplies for cosmetic purposes or for conditions that are a result of hereditary or developmental defects (such as cleft palate, upper and lower jaw malformations, congenitally missing teeth, and the bleaching of teeth that are discolored or lacking enamel).
- Services and supplies for restoring tooth structure lost from wear, rebuilding or maintaining chewing surfaces due to alignment or occlusion or stabilizing of the teeth.
- Prosthodontic services and supplies or any single procedure that began before coverage for you or your Eligible dependents started under the Dental Plan. A single procedure is defined as a dental procedure to which a separate procedure number is assigned.
- Prescribed drugs, premedication or analgesia.
- Prophylaxis (cleanings), if the participant has already received two cleanings (including cleanings provided during periodontal procedures) covered by the Plan in the current calendar year.
- Hospital costs and additional fees charged by a dentist or physician for hospital treatment.
- Anesthesia or sedation, except general anesthesia or sedation administered by a licensed dentist or physician in connection with covered oral surgery, select endodontic and periodontal surgeries, and except for children under age 3 or other individuals whose special needs require general anesthesia or sedation to enhance the safety and success of the procedure.
- Extraoral grafts (grafting of tissues from outside of the mouth to oral tissue).
- Bone grafts in conjunction with, or subsequent to, extractions or implant procedures. Periodontal surgery, where bone grafting is performed, is covered only when performed on natural teeth.
- Diagnosis or treatment of any condition related to temporomandibular (jaw) joint dysfunction (TMJD) or associated musculature, nerves and other tissues.
- Replacement of existing restorations for any purpose other than restoring active carious lesions (tooth decay).
- Services or supplies which are experimental in nature, as determined by Delta Dental. Experimental services and supplies include any treatment, therapy, procedure, equipment or equipment usage, device or device usage, or supplies which Delta Dental determines in its sole discretion are not recognized, in accordance with generally accepted professional dental care standards, as being safe and effective for use in the treatment of the illness or condition at issue.
- Services and supplies covered under any other Company-sponsored health plan or benefit program.
- Services and supplies for cast restorations due to cracks, fracture lines or "craze lines" unless there is significant tooth structure missing due to decay or fracture that results in displacement of the tooth structure.

- Services and supplies which are not necessary and customary dental care, as determined by Delta Dental.
- Charges for failure to appear as scheduled for an appointment.
- Services for completion of claim forms or filing of claims.
- Replacement of lost or stolen prosthetic devices.
- Services or supplies rendered or furnished with any duplicate prosthetic device, denture, or any other duplicate appliance.
- Repair or replacement of an orthodontic appliance furnished, in whole or in part.
- Educational programs, such as training in plaque control or oral hygiene, or for dietary instructions.
- Sealants (except as stated under Plan Limitations).
- Services or supplies in connection with periodontal splinting.
- Benefits provided under the extension of benefits provisions of any disability insurance policy, dental care service, hospital service plan contract or self-insured welfare benefit plan.
- Benefits provided under any other dental care service plan contract, or under any similar group contractual arrangement (such as an HMO contract).
- Cone beam image capture only is not a covered Benefit.

Additional exclusions apply to all the health care plans. See "Reductions/Exclusions for Duplicate Coverage."

Some of the items not covered by the Dental Plan may be covered by your medical plan, if medically necessary. Please check with your medical plan's member services department for more information.

Third Party Exclusion

The Plan contains exclusions for injury, illness or other conditions for which a third party may be liable or legally responsible by reason of negligence, intentional action or breach of legal obligation. These exclusions, limitations, and conditions are described under "Subrogation and Reimbursement."

Claims and Appeals

Delta Dental will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. For post-service claims, if you have provided all of the information needed to process the claim, we will notify you within thirty (30) days of receipt of the claim, unless an extension of up to fifteen (15) days is necessary due to matters beyond the control of the Plan. If an extension is necessary, we will notify you of the circumstances requiring the extension before the end of the thirty (30) day period and provide the date by which we expect to render a decision. If the extension is necessary because you have not submitted the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice to provide the specified information.

For pre-service claims involving urgent care, we will notify you of the Plan's benefit determination (whether or not adverse) as soon as possible, taking into account the dental exigencies, but no more than seventy-two (72) hours after receipt of the pre-service claim, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. Notice of a decision on an urgent care pre-service claim may be provided orally within this time frame, provided that written or electronic notice is provided no less than three (3) days after the oral notification. If you fail to provide sufficient information for us to decide an urgent care pre-service claim, we will notify you of the specific information necessary to complete the claim as soon as possible, but no later than twenty-four (24) hours after receipt of the pre-service claim. We will allow additional time for you to provide the specified information. The additional time will be a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours. In such cases, we will notify you of our benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of (i) the receipt of the specified additional information, or (ii) the expiration of the period afforded you to provide the specified additional information.

For purposes of the dental benefit, a "claim involving urgent care" is any claim for care or treatment with respect to which the application of the time periods for making non-urgent care determinations (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of a licensed clinical professional with knowledge of the claimant's dental condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is a "claim involving urgent care" is determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a licensed clinical professional with knowledge of the claimant's dental condition determines is a "claim involving urgent care" shall be treated as a "claim involving urgent care" for purposes of the Plan's claims and appeals provisions.

If we have approved an ongoing course of treatment to be provided over a period of time or number of treatments, then the following applies:

- Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. We will notify you of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- Any request by you to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and we will notify you of the benefit determination (whether adverse or not) within twenty-four (24) hours after we receive the claim, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

The Plan does not currently require prior authorization to receive benefits, so you are not currently required to follow procedures for pre-service claims.

Notice of Claim Denial

If your claim is denied, we will notify you in writing and provide the following:

- The specific reason(s) for the denial;
- Specific references to the pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such material or information is necessary;
- An explanation of the Plan's review procedures and the time limits applicable to such procedures;
- Your right to bring a civil action under ERISA Section 502(a) after exhausting all claims and appeals processes;
- If your claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or a notice of where and how you can obtain a copy, free of charge;
- If your claim for benefits is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion; or include a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request;
- In the case of a denial concerning a claim involving urgent care, a description of the expedited review process applicable to such claims; and
- A statement that additional information regarding voluntary alternative dispute resolution options, such as mediation, may be obtained by contacting your local U.S. Department of Labor Office.

If the denial concerns a claim involving urgent care, the information described above may be provided to the claimant orally within the applicable time period described in "Timing of Claim Decision," provided that a written or electronic notification is furnished no later than three (3) days after the oral notification.

Timing of Appeal

You have at least 180 days after receiving a notice of denial to request an appeal or grievance by writing to us giving reasons why you believe the denial was wrong. You and your Provider will have the opportunity to submit written comments, documents, records, and other information relating to the claim and may ask Delta Dental to examine any additional information provided that may support the appeal or grievance. Upon request and free of charge, you will be provided reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits (other than legally or medically privileged documents), a copy of any internal rule, guideline, protocol and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying the claims.

Send your appeal or grievance to us at the address shown below:

Delta Dental of California
Customer Service Department
P.O. Box 997100
Sacramento, CA 95899
Phone Number: 888-335-8227

Review of Appeal

For appeals of post-service claims, we will send you a written acknowledgment of receipt within five (5) days upon our receipt of the appeal or grievance. We will make a full and fair review and may ask for more documents during this review if needed. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered in the initial claim determination. The review will be conducted for us by an appropriate person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. The review does not afford deference to the initial adverse benefit determination.

If your appeal is based in whole or in part on a clinical judgment, including determinations with regard to whether a particular treatment, drug, or other item is an experimental, investigational, or unproven service or not medically necessary or appropriate, the appropriate named person will consult with an appropriately trained and experienced dentist, who will not be the individual who was consulted in connection with the initial claim determination that is the subject of the appeal nor the subordinate of such individual. Upon request, we will provide for the identification of any licensed clinical or vocational experts whose advice was obtained in connection with the denial of your claim, without regard to whether the advice was relied upon in making the claim determination.

In the case of a claim involving urgent care, (i) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and (ii) all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

Notice of Appeal Decision

For appeals of post-service claims, we will send you a written decision within sixty (60) days after receipt of your appeal or grievance. If your appeal is denied, the notice will include the following:

- The specific reason(s) for the denial;
- Specific references to the pertinent Plan provisions on which the denial is based;
- Your entitlement to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures;
- Your right to bring a civil action under ERISA Section 502(a) after completion of all required levels of review;

- If your claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or a notice of where and how you can obtain a copy free of charge upon request;
- If your claim for benefits is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion; or include a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

For a claim involving urgent care, we will notify you of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of your request for review of an adverse benefit determination.

PG&E's Voluntary Claims and Appeals Review Process

If you are not satisfied with the claims and appeals review process completed with Delta Dental, you may elect to use PG&E's Voluntary Claims and Appeals Review Process, as described below. You have 90 days from the date of receipt of the final decision from Dental Delta to elect this voluntary claims and appeals review process. Initiation of the Voluntary Claims and Appeals Review Process does not restrict your ability to bring a civil action against the Plan.

The first step of the Voluntary Claims and Appeals Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include an AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PERSONAL HEALTH INFORMATION form. You can access a copy online at mypgebenefits.com > Resources > Legal Notices, or by calling the PG&E Benefits Service Center at **1-866-271-8144**.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
Appeals
300 Lakeside Drive
Oakland, CA 94612

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the Authorization form may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

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

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to
Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

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

- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under section 502(a) of ERISA.

Vision Coverage

Vision care is administered by Vision Service Plan (VSP), with 137,000 nationwide access points. While you may receive vision care from any doctor you choose, using a VSP-network doctor has two advantages:

- Vision Service Plan pays VSP doctors directly, so there are no claim forms to submit. If you go to a non-VSP doctor, you will have to pay the doctor yourself and then file a claim with VSP for reimbursement. Your benefits will be less if you use a non-VSP doctor.
- Exams, standard lenses and frames, or medically necessary contact lenses from VSP doctors are covered after you pay a $10 exam copayment and/or a $25 materials (lenses and/or frames) copayment. Both copayments apply to each covered person. Please see "How the Plan Works" for more details. For services and supplies you receive from non-VSP doctors, you will receive an allowance from VSP for covered services which generally will not fully reimburse you for all of your expenses.

How the Plan Works

To be assured of full benefits from Vision Service Plan (VSP), you must receive care from a doctor who is a participating member of the VSP network. You are not required to obtain an authorization form to use your VSP benefits. Simply follow these steps:

Questions?

Call 1-800-877-7195 if you have questions regarding any VSP services.

- **Contact your VSP network doctor to make an appointment. If you need help locating a VSP network doctor, call VSP at 1-800-877-7195. You can also access VSP's website at vsp.com for a list of participating doctors or to obtain information on your eligibility.**
- **Identify yourself, or your dependent, as a VSP member when calling your doctor's office. Provide your name, date of birth and, if necessary, the last four digits of your Social Security number and tell the doctor that you are an employee of the Company. Your doctor will verify your eligibility and coverage with VSP and then obtain the necessary authorization for services.**
- **After you pay a $10 exam copayment and/or a $25 materials copayment, VSP will pay your VSP doctor directly for all remaining covered charges. Any additional charges for your frames and lenses beyond VSP's network allowances will be your responsibility. Please refer to "Extra Charges" for more information.**
- **Essential Medical Eye Care : For an additional copayment of $20, this program provides for additional eye care services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma and more. Fully covered retinal screening for members with diabetes.**

Non-VSP Providers

When you receive vision care from an out of network provider, you pay the provider yourself and then submit a claim for reimbursement. Send a copy of the itemized bill(s) to VSP with an HCFA-1500 form or any generic insurance claim form that may be available from your non-participating provider.

The following information must also be included in your documentation:

- patient's name and mailing address; and
- your identification number (usually the employee's Social Security number).

Mail the itemized bill(s) and claim form to the following address:

Vision Service Plan
P.O. Box 495933
Cincinnati, OH 45249

Claims can also be submitted online on vsp.com. Just sign on to vsp.com, select the "Out-of-Network Reimbursement Form" and follow the instructions.

Please note that claims for reimbursement must be filed within 12 months of the date on which services were completed. You will be reimbursed according to a schedule of allowances. (See "What the Plan Does Not Cover.")

VSP's network of doctors is only in the United States. Reimbursements for the services of non-network providers outside the United States are based on the currency conversion rate on the date of service.

Benefits with VSP Providers

When you use a VSP network provider, after you pay a $10 exam copayment and/or a $25 copayment for materials (lenses and/or frames), VSP provides:

- Vision exams — Once every 12 months.
- Essential Medical Eye Care exam — Additional copayment of $20 is required. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service. See program description below.
- Routine Retinal Screenings – covered with a $39 copayment. Every 12 months
- Prescription lenses
  - Eyeglass lenses — Every 12 months, provided you need them. There is an extra charge for non-covered lens enhancements (see "Extra Charges"). The extra cost is your responsibility.
  - Medically necessary contact lenses — Medically necessary contact lenses are covered in full from a VSP doctor for certain eye conditions that would prohibit the use of glasses. Your VSP doctor will obtain authorization from VSP. You will not be entitled to benefits for eyeglass lenses and/or frames for 12 months following the date on which medically necessary contact lenses are received.
  - Elective contact lenses — Elective contacts are those that are not considered to be medically necessary. If you choose elective contacts, VSP will pay up to $150 toward the contacts. The contact lens exam has an up to $55 copay and includes evaluation/fitting fees. You will not be entitled to benefits for eyeglass lenses and/or frames for 12 months following the date on which elective contact lenses are received.
  - Ultraviolet (UV) protected lenses — Covered at 100% after copayment, if received from a VSP doctor.
  - Photochromic lenses (lenses that darken in the sunlight) — Covered at 100% after copayment, if received from a VSP doctor.
- Frames — Every 24 months, provided you need them. Many designs are available at no charge after you pay your $25 copayment; however, you will be responsible for any cost that exceeds the $150 plan allowance. You can get an extra $20 to spend on featured frame brands from your VSP Doctor. Go to www.vsp.com/extra20 for details and a complete list of featured brands.

- Lasik surgery — Covered if performed by a VSP doctor, up to $250 per eye (lifetime limit).

Essential Medical Eye Care The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes. For more information, contact VSP.

Benefits with Non-VSP Providers

If you do not use a VSP network doctor, your reimbursement will be limited to the following schedule:

Schedule	
Exam	$45
Lenses	
Single Vision	$30
Bifocal	$50
Trifocal	$65
Lenticular	$100
Progressive	$50
Ultraviolet (UV) Protected	Not covered
Photochromic	Not covered
Frames	$70
Contacts	
Medically Necessary	$250
Elective	$105 (including contact lens exam)
Lasik Surgery	Not covered

What the Plan Does Not Cover

The Vision Plan does not cover:

- Services or supplies that are not covered expenses, as determined solely by VSP.
- Orthoptics or vision training and any associated supplemental testing; plano (non-prescription) lenses; or two pairs of eyeglasses, in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available Medical or surgical treatment of the eyes
- Corrective vision treatment of an Experimental Nature Costs for services and/or materials above Plan Benefit allowances. Services and/or materials not indicated on this Schedule as covered Plan Benefits .
- Laser eye surgery performed by non-VSP providers.

Additional exclusions apply to all the health care plans. See “Reductions/Exclusions for Duplicate Coverage.”

Extra Charges

The Vision Plan covers vision care services that are medically necessary. You will have to pay an extra charge for certain services that are primarily for cosmetic purposes. These include, but are not limited to:

- Blended lenses
- Contact lenses (except as noted)
- Oversized lenses
- Photochromic lenses (lenses that darken in the sunlight) obtained from non-VSP providers
- Tinted lenses, except pink #1 and pink #2
- Progressive multifocal lenses
- Coating or lamination of lenses
- Frames that cost more than the VSP allowance
- Low vision care (certain limitations apply)
- Cosmetic lenses
- Optional cosmetic processes
- Ultraviolet (UV) protected lenses obtained from non-VSP providers
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.

Polycarbonate lenses. Value-Added Discounts from VSP Doctors

40% savings on additional pairs of prescription glasses from same VSP network provider who performed your WellVision exam within 12 months of your last exam. 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision exam.You can also get an extra $20 to spend on featured frame brands from your VSP Doctor. Go to www.vsp.com/extra20 for details and a complete list of featured brands.

Your VSP doctor will also provide a 15% discount off the cost of your contact lens exam (fitting and evaluation). The discount does not apply to the cost of the contact lenses.

The most popular lens enhancements are covered after a copay, saving you an average of30% ; see your VSP doctor for special pricing on additional lens enhancements. Your VSP doctor will provide a 20% discount on your out-of-pocket costs if you choose a frame valued at more than your plan allowance.

Claims and Appeals

For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Care Plan for Active Employees, see the *Health Care Participation*.

Claims

Vision Service Plan (VSP) is the Claims Administrator for the Vision Plan. VSP has a network of doctors who provide vision services and who will file a claim with VSP on your behalf. You simply make the appropriate copayments to the provider.

If you use a non-participating provider, you will be required to pay the provider and file a claim with VSP. Claim forms are available by calling VSP at **1-800-877-7195**, or visit VSP's website at vsp.com. If your claim is approved, the appropriate benefits will be paid to you. All claims for vision plan benefits must be made within 12 months of the date on which services or materials were received.

After your claim is processed, VSP will send you a written notice of its decision within 30 days of receipt of your claim. If your claim is denied in whole or in part, the notice will include the specific reason(s) for the denial and references to the specific plan provision(s) on which the denial is based. You will also receive a description of any additional information needed to obtain approval of your claim and an explanation of why it is necessary. Upon request and free of charge, VSP will provide a copy of the applicable regulation, protocol, and/or explanation of any scientific or clinical judgment used in the denial. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Complaints and Appeals

Before you officially appeal a denial of a vision claim, you can call VSP at **1-800-877-7195** to see if an informal resolution is possible. However, if you aren't satisfied with VSP's explanation of why the claim was denied, you can request to have the claim reviewed.

VSP will handle and resolve your benefit issues differently, depending on whether your issue is a complaint or an appeal. Under each type of resolution approach, you should first call VSP at **1-800-877-7195**.

Complaints

If you ever have a complaint, your first step is to call VSP's Member Service Department's number at **1-800-877-7195**, Monday through Saturday, between 6 a.m. and 5 p.m. Pacific time. Complaints are defined as dissatisfactions regarding access to care, quality of care, treatment, or service. You also have the right to submit written comments or supporting documentation concerning a complaint to assist in VSP's review. Every effort will be made by VSP's Member Service Department to answer your question and/or resolve the matter informally. If a matter is not initially resolved to your satisfaction, you may communicate a complaint to VSP in writing by using a complaint form, which may be obtained upon request from VSP's Member Service Department.

Your complaint form should be sent to:

Vision Service Plan
Attn: Complaints and Grievance Unit
P.O. Box 997100
Sacramento, CA 95899-7100

Upon receipt of a verbal or written complaint, VSP will acknowledge, in writing, the receipt and/or disposition of the complaint within five calendar days. VSP will resolve the complaint within 30 calendar days of receipt.

Appeals

If you are not satisfied with a VSP claim decision, you or your authorized representative may submit a written appeal to VSP. Your appeal must be submitted in writing within 180 days of the date on which the claim was denied. Your appeal should include the name, address and Member number of the employee, along with the name and date of birth of the participant (which may be you or your Eligible Dependent), the name of the provider of services, the claim number, and reason for appealing along with any evidence you want reviewed.

Send your appeal to:

VSP
Member Appeals

P.O. Box 2350
Rancho Cordova, CA 95670

VSP's review will take into account all of the information you submit with your appeal, regardless of whether such information was submitted or considered in the initial claim decision. VSP's review determination will be completed within 30 calendar days of VSP's receipt of your request for review.

If, on appeal, VSP determines that your explanation and additional information support the payment of your claim, VSP will process your claim. If your appeal is denied, you will be provided with the specific reason(s) for the decision and the Plan provision(s) on which the decision was based. You have the right to receive, only upon request and at no charge, the information that VSP used to review your appeal.

If you are not satisfied with VSP's decision, you may request a second level of review within 60 calendar days from the date of the determination. VSP shall resolve any second level appeal within 30 calendar days.

PG&E Voluntary Claims and Appeals Review Process

If you are not satisfied with the claims and appeals review process completed with VSP, you may elect to use PG&E's Voluntary Claims and Appeals Review Process, as described below, or elect to bring a civil action. You have 90 days from the date of receipt of the final decision from VSP to elect this voluntary claims and appeals review process. Initiation of the Voluntary Claims and Appeals Review Process does not restrict your ability to bring a civil action against the Plan.

The first step of the Voluntary Claims and Appeals Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include an AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PERSONAL HEALTH INFORMATION form. You can access a copy online at mypgebenefits.com > Resources > Legal Notices, or by calling the PG&E Benefits Service Center at **1-866-271-8144**.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
Appeals
300 Lakeside Drive
Oakland, CA 94612

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the Authorization form may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

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

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

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

- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under Section 502(a) of ERISA.

Flexible Spending Accounts (FSAs)

The IRS allows you to pay for certain health care and dependent care services with before-tax dollars. You can enjoy this tax advantage by setting up flexible spending accounts (FSAs) each year.

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation.

For IRS purposes, your deposits are not technically "paid" to you before going into the accounts, so they bypass all income tax withholding. Therefore, federal income taxes, Social Security taxes, Medicare taxes and most state income taxes are not withheld from any of these deposits, nor are any such taxes due when the money is used to pay for eligible expenses.

Additional Information

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

Note that the Dependent Care Flexible Spending Account (DCFSA) is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

How this Section Is Organized

Health Care Flexible Spending Accounts (HCFSAs) and Dependent Care Flexible Spending Accounts (DCFSAs) are very similar and follow many of the same rules. To help you keep the rules straight, this section describes how HCFSAs and DCFSAs work, and then provides specific explanations of each of these two accounts.

Plan Documents and Administration

The plan documents for The Pacific Gas and Electric Company Health Care Flexible Spending Account Plan and The Pacific Gas and Electric Company Dependent Care Flexible Spending Account Plan incorporate the terms of this Summary of Benefits Handbook that pertain to the relevant plan as well as the applicable terms of Open Enrollment materials (which constitute Summaries of Material Modifications with respect to the Health Care Flexible Spending Account Plan).

Unless otherwise noted, if there is a conflict between a plan document and this Summary of Benefits Handbook, the plan document controls. If the plan document is silent on a specific issue, then this Summary of Benefits Handbook controls on that issue.

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

The Pacific Gas and Electric Company Dependent Care Flexible Spending Account Plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

How Health Care Flexible Spending Accounts (HCFSAs) and Dependent Care Flexible Spending Accounts (DCFSAs) Work

There are two types of flexible spending accounts (FSAs):

- Health Care Flexible Spending Account (HCFSA)
- Dependent Care Flexible Spending Account (DCFSA)

The HCFSA allows you to set aside before-tax contributions to reimburse yourself for eligible health care expenses that are not covered by health care plans. The amount may change from year-to-year. Visit mypgebenefits.com > Financial Health > Spending Accounts to review the current before-tax contribution limit ($3,300 in 2026).

The DCFSA allows you to set aside before-tax contributions to reimburse yourself for eligible expenses incurred to care for children and other eligible individuals so you can work or attend school. You can allocate up to $7,500 a year per individual or married couple filing a joint tax return. (Employees with a spouse filing separate tax returns may each contribute up to $3,750.)

Eligibility, Enrollment and Administration

You are eligible to enroll in the flexible spending accounts (FSAs) only during very specific times:

- When you are first hired,
- When you enroll during Open Enrollment each year, or
- When you have an eligible mid-year election change event (see "Mid-Year Election Change Events").

You set up your FSA(s) by designating an annual contribution amount when you enroll.

You are not eligible for FSA benefits if you are a temporary additional employee, an outage employee, a probationary intermittent employee, an employee excluded under a union agreement, a contract or agency employee, an intern, a summer hire, or a retiree of the Company (unless you have been rehired and you are actively working in an eligible Union-represented position), or an employee receiving long-term disability benefits.

Claims Administrator

The Health Care Flexible Spending Accounts (HCFSAs) and Dependent Care Flexible Spending Accounts (DCFSAs) are administered by a third-party claims administrator:

- Optum Financial if you are an Anthem Blue Cross (Anthem) member or if you have waived PG&E-sponsored medical coverage, or
- Kaiser Health Payment Services if you are a Kaiser Permanente member.

If you have any questions about the Plan, IRS rules, or your claims, you may contact:

If you are an Anthem member or you have waived PG&E-sponsored medical coverage	If you are a Kaiser member
Optum Financial 1-866-271-8144 Service hours: 7:30 a.m. to 5 p.m., Pacific time, Monday through Friday	Kaiser Health Payment Services 1-877-750-3399 Service hours: 7 a.m. to 7 p.m., Pacific time; Monday through Friday

Setting Up Your Flexible Spending Accounts

When you are first hired and during each annual Open Enrollment thereafter, you should estimate your anticipated out-of-pocket expenses for health care and dependent care for the upcoming year and decide how much, if anything, you wish to contribute to each account. You cannot set up or make changes to these accounts

at any other time of the year, unless you have an eligible change-in-status event (see "Mid-Year Election Change Events").

If you decide to set up either or both accounts, you must indicate the annual amount you wish to contribute. This is called your annual "goal."

Health Care Flexible Spending Account (HCFSA)

The HCFSA contribution amount changes from year to year. Visit mypgebenefits.com > Financial Health > Spending Accounts to review the current before-tax contribution limit ($3,300 in 2026).

Dependent Care Flexible Spending Account (DCFSA)

You can allocate up to $7,500 a year per individual or married couple filing a joint tax return. (If you have a spouse filing a separate tax return, you may each contribute up to $3,750.)

Your annual contributions to a Dependent Care Flexible Spending Account (DCFSA) cannot exceed your spouse's income or your own. For example, if you earn $30,000 per year and your spouse earns $4,000 per year, you may contribute up to $4,000 to the DCFSA, if you are filing jointly. Special limits apply if your spouse is a full-time student or mentally or physically disabled.

The contribution rules for married individuals do not apply to an employee with a registered domestic partner. Domestic partners are considered two unattached individuals who can open separate FSAs, each with the applicable individual contribution limits as prescribed by the IRS.

For more information, contact Optum Financial at **1-866-271-8144** if you are an Anthem member or you have waived PG&E-sponsored medical coverage, or contact Kaiser Health Payment Services at **1-877-750-3399** if you are a Kaiser member.

Required Contribution Changes

The Company may reduce the amount of your contributions, stop your contributions during the year, or treat part or all of your contributions and reimbursements as taxable income to comply with applicable laws and regulations. You will be notified if your flexible spending accounts (FSAs) are affected.

Putting Money into Your Flexible Spending Accounts (FSAs)

You may contribute to the flexible spending accounts (FSAs) by making deposits to your FSAs (both your HCFSA and your DCFSA) through payroll deductions from your before-tax pay. Then, when you incur an eligible health care or dependent care expense, as defined by the IRS, you use these accounts to "reimburse" yourself on a before-tax basis. Your deposits go directly into your accounts in equal portions each month. For monthly-paid employees, an equal amount will be deducted from each of your monthly paychecks before taxes. For biweekly-paid employees, an equal amount will be deducted from your second paycheck of each month before taxes. By the end of the Plan year, your total contribution goal will have been placed in your account, unless you go on an unpaid leave of absence.

If you participate in both the HCFSA and the Health Account, there are special rules governing which account will be used to pay your claims. Your health care debit card, as well as the automatic reimbursement process (for Kaiser members only), is programmed to deduct money first from your HCFSA to help you avoid forfeiture of unused amounts at the end of the year.

Plan carefully, however, because both types of FSA are subject to the IRS' "use it or lose it" rules. See "Flexible Spending Account (FSA) Limitations" for more information.

Exceptions to the "Use It or Lose It" Rule

For the HCFSA, in general, any unused balance will be forfeited at the end of the year. However, you can carry over unused balances up to a certain amount to the next year as long as you are eligible to participate in the HCFSA as of January 1 of the next year.

For the DCFSA, in general, any unused balance amount will be forfeited at the end of the plan year. However, there is a grace period that ends March 15 of the following Plan year, during which you can incur expenses against contributions made in the current year.

Visit mypgebenefits.com > Financial Health > Spending Accounts > for more information.

Changing Your Annual Contribution Amount

Health Care Flexible Spending Account (HCFSA)

Normally, you may not change the amount you contribute to your Health Care Flexible Spending Account (HCFSA) or stop payroll deductions mid-year. However, you may be able to increase or decrease your current HCFSA annual contribution goal during the year if you have an eligible mid-year election change event (see "Mid-Year Election Change Events").

Dependent Care Flexible Spending Account (DCFSA)

You may make a change in the annual amount you contribute only if you have an eligible mid-year election change event (see "Mid-Year Election Change Events").

You may also make a corresponding change to your Dependent Care Flexible Spending Account (DCFSA) if you replace one dependent care provider with another or if there is a change in the cost for the services of a caregiver who is not a relative. However, the IRS will not allow a mid-year change to your DCFSA for a change in the fee charged by a relative. For example, if your child's daycare center increases its fees, a change in your DCFSA would be allowed. Similarly, if you want to change from using a daycare center to employing an aunt to watch your child, an election change would be permitted even though the aunt is related to you. If later, however, you decide to give your aunt a raise, you may not make a mid-year election change to reflect the raise. Please remember, your DCFSA may be canceled only under certain circumstances (for example, if you switch from a childcare facility to a relative or friend who will not charge you for the services provided).

Health Care Flexible Spending Account (HCFSA)

You use the money in your Health Care Flexible Spending Account (HCFSA) to "pay" for eligible health care expenses. See "Eligible Expenses" for further details.

When you incur expenses that are eligible for reimbursement, you may "withdraw" the money from your HCFSA.

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

If you are an Anthem member or you have waived PG&E-sponsored medical coverage	If you are a Kaiser member
▪ Go to the Benefits Portal (accessible by computer through PG&E@Work For Me or mypgebenefits.com) and click on the Optum Financial link. This will take you straight to your Optum Financial account, without having to create an Optum Financial username and password. ▪ You may also access your Optum Financial account directly by visiting OptumFinancial.com, but you will need to register your account if you do so. To register, click 'Sign In' at the top and then select Individuals and families. Next, click the 'Register' button on the 'Optum Financial' tile. ▪ Once logged in, you can access your account balance or enter a new claim. Your account details are available at any time online, or over the phone at 1-866-271-8144.	▪ Go to kp.org/healthpayment.kp.org/healthpayment. ▪ Sign in with your user ID and password. ▪ If you are a new participant, choose "Register for an account" and complete the online registration form. ▪ Once logged in, you can access your account balance or enter a new claim. Your account details are available at any time online, or over the phone at 1-877-750-3399.

How to Pay for Eligible Health Care Expenses

There are several different ways in which you can pay for eligible health care expenses with your HCFSA funds, including: automatic reimbursement (available to Kaiser members only); using your health payment card at the time of service; paying for the expense out of your own pocket and then filing a claim to reimburse yourself; or having your FSA Administrator pay your provider online.

Automatic Reimbursement (for Kaiser Members only)

Kaiser will process your claim and determine any coinsurance or deductible liability that you owe out of your own pocket.

If you have sufficient funds in your HCFSA and/or credits in your Health Account, Kaiser Health Payment Services will automatically pay your Kaiser provider for any amount you owe; you do not have to file any claims for claims incurred at Kaiser providers.

Kaiser members can turn off the automatic payment feature any time in the calendar year. However, once turned off, it cannot be turned on again until the next calendar year. If you do turn off this feature, you will have to file a claim when you incur an eligible expense (outlined below). You must call Kaiser Health Payment Services at **1-877-750-3399** in order to turn off the automatic payment feature for each benefit plan year.

If you have an enrolled domestic partner under the HAP who does not qualify as your eligible dependent, you must turn off the automatic reimbursement process under the Health Care FSA in order to comply with IRS regulations concerning reimbursement for non-eligible dependents. Please call Kaiser Health Payment Services at **1-877-750-3399** to turn off the automatic reimbursement option.

Use Your Health Payment Card

You'll automatically receive a health care payment card in the mail when you enroll in the HCFSA. You'll receive a single card even if you're enrolled in more than one account (e.g., HCFSA and Health Account). A card is not available for use with the DCFSA.

If you are an Anthem member or you have waived PG&E-sponsored medical coverage	If you are a Kaiser member
▪ Optum Financial will mail you an Optum Financial health payment card. ▪ Activate your card by following the instructions provided. ▪ Your card can be used for eligible health care expenses. See "Eligible Expenses" for further details. ▪ Your debit card is programmed to work only at providers whose primary business is to provide health care or health care-related products.	▪ Kaiser Health Payment Services will mail you a Kaiser health payment card. ▪ Activate your card by following the instructions provided. ▪ Your card can be used for eligible health care expenses. See "Eligible Expenses" for further details. ▪ Your debit card is programmed to work only at providers whose primary business is to provide health care or health care-related products.

The available balance on your card will reflect your total annual HCFSA contribution amount, minus any claims that have been paid. This amount is available right away, even before you've made all your annual contributions.

If you have more than one account, the available balance on your card will reflect the total available for all accounts. When you swipe your health care debit card, the system makes sure that your account is active and that you have sufficient funds for the full amount. If you do not have funds for the full amount, the transaction will be denied. As an alternative, you can pay out of pocket and file a claim for reimbursement.

Although your health payment card eliminates the need to file paper claims, your charges must be verified. Optum Financial or Kaiser Health Payment Services will notify you if more information is needed. If Optum Financial or Kaiser Health Payment Services has your email address on file, your notification will be electronic. Otherwise, it will be by mail. If you use the health payment card for an ineligible expense or an expense for which Optum Financial or Kaiser Payment Account Services does not have proper documentation, you will be required to reimburse the account for the amount of that transaction.

If you need to order a replacement or additional health payment card, you can log on to your online account or call Optum Financial at **1-866-271-8144 or** Kaiser Health Payment Services at **1-877-750-3399** to request another card. Be sure to call if your card is lost or stolen.

For details on how to use your health care debit card and more information about how to submit expenses, contact your account administrator.

Pay for the Expense and File a Claim

You can pay for out-of-pocket expenses using your own personal credit or debit card, cash or check, and then file a claim to reimburse yourself for the expense. Make sure you keep your itemized receipt(s) as documentation. To reimburse yourself, log in to your online account and file a reimbursement claim. For Kaiser members, this option applies when:

- you have opted out of the Automatic Reimbursement feature described above; or
- you are paying for services not covered under the HAP; or
- you paid for an eligible expense using your own money and need to be reimbursed. Here's how online or paper claim processing works:

1. **You may pay for the expense**, although it is not necessary to pay the expense prior to submitting your claim for reimbursement. Nevertheless, you are responsible for paying all invoices on time, regardless of when you receive your reimbursement. If Optum Financial or Kaiser Permanente asks you to verify an expense on your card, you'll need to submit an Explanation of Benefits (EOB) or itemized receipt.
2. **If a portion of a health care expense is covered by any insurance for which you are eligible, file a claim under that plan first.** You should receive an Explanation of Benefits (EOB) or similar statement showing how much the plan paid, if anything. If you do not receive an EOB, contact the claims administrator or insurance company and request one. You also may submit an itemized print-out from your health plan's website.
3. **Log in to your online account to file for a claim for reimbursement and submit your supporting documentation** (e.g., itemized receipt or EOB) by uploading, faxing, or mailing the documentation to the administrator. If Optum Financial is your FSA Administrator, go to the Benefits Portal and click on the Optum Financial link. If you are a Kaiser member, go to kp.org/healthpayment and enter your username and password. Follow the prompts to file a claim. Both Optum Financial and Kaiser also have mobile apps to file claims. You can download the Optum Financial app or Kaiser's mobile app. Both Optum Financial and Kaiser's mobile apps are available through the iTunes app store and the Google Play Android store.

If you need help determining which of your expenses are eligible, you should contact Optum Financial or Kaiser Health Payment Services. Eligibility for reimbursement is based on when expenses are actually incurred, regardless of when you pay for such expenses.

You may also print and mail the completed claim submission form, along with original invoices, receipts, EOBs, or health plan website claims print-outs, to your FSA Administrator's address below. Be sure to keep a photocopy of everything for yourself before you submit it to Optum Financial or Kaiser Health Payment Services. Or you may fax your completed claims submission form and a copy of the original invoices to your FSA Administrator at the fax number below. Save a copy of your fax confirmation receipt as proof of successful submission.

If you are an Anthem member or you have waived PG&E-sponsored medical coverage	If you are a Kaiser member
Mail claim and documentation to: Optum Financial Claims Administrator P.O. Box 622317 Orlando, FL 32862-2317 Or fax to: 443-681-4602	**Mail claim and documentation to:** Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540 Or fax to: 1-877-535-0821

Pay Your Provider Online

You can pay many of your eligible health care expenses directly from your FSA account.

Optum Financial Members:

- Log on to your Optum Financial account from the Benefits Portal.
- Click on "Submit Receipt or Claim," then select "Pay Provider."
- Follow the online instructions. You will need to provide an invoice or other appropriate documentation for the expense. Optum Financial will mail payment to your provider in accordance with Optum Financial payment guidelines. If you have recurring expenses, select "Make Recurring Monthly Payments" and follow the online instructions to set up automatic payments.

Kaiser Members:

- Log on to kp.org/healthpayment using your Kaiser username and password
- Click on "File a Claim."
- Select which account you want the funds to come from (e.g., FSA or Health Account). If you have funds in your HCFSA, you should select "FSA," as FSA funds should be used prior to your Health Account credits.
- Input or select a Payee.
- Upload your receipt(s).
- Input your claims information (i.e., provider name, date, amount, etc.).

Processing of Manual Claims

Optum Financial Claims

Claims are processed daily. If you file a claim to reimburse yourself for out-of-pocket expenses that you have incurred, after your claim is processed, you'll receive a reimbursement check mailed to your home, or you can elect direct deposit into your bank account at OptumFinancial.com. If you choose automatic deposit for your FSA reimbursements for any calendar year, the election will automatically roll over when you re-enroll in the Plan for a future year.

Kaiser Claims

Unless you elect to decline Automatic Reimbursement, your Kaiser medical providers will automatically be paid if you have enough funds in your HCFSA. However, if you need to file a manual claim (for example, if you incur a non-covered medical expense or a dental expense), log in to kp.org/healthpayment and click on "File a Claim." Then select which account you want the funds to come from (e.g., Health Account or FSA), select a Payee (yourself or another provider), upload your receipt(s) and follow the remaining online steps. Reimbursement checks issued to you and not cashed within six months of issuance will be considered forfeitures.

How to Avoid Overpayment/Unverified Expenses

When you pay for health care expenses at the doctor, pharmacist, hospital, dentist, or eye doctor, always present your health insurance ID card first to ensure your claims are filed correctly.

You'll usually be required to pay for prescriptions upfront before you receive the prescription. However, for other types of expenses, don't pay right away. Instead, wait until your claim is processed and you receive your Explanation of Benefits (EOB). This helps avoid overpayment. Compare your EOB with the provider bill to verify the amount being charged by your provider is the same as the patient balance on the EOB. You then may pay using your health care debit card, or you may use your own personal credit/debit card, cash or check and then request reimbursement afterwards. Another way to incur an overpayment or unverified expense is if your FSA Administrator does not have enough information to substantiate a claim. If your FSA administrator asks you to verify an expense on your card, you'll need to submit an Explanation of Benefits (EOB) or itemized receipt.

If you have any type of overpayment or unverified expense, there are three ways you can resolve the situation:

1. Submit a valid receipt or EOB for the expense;
2. Submit a substitute receipt for a different expense; or

3. Fully or partially repay the overpayment or unverified expense.

If you fail to clear overpayments and/or unverified expenses, the total amount of the ineligible expenses may be added to your W-2 as taxable income.

Always Save Your Itemized Receipts

Always save your itemized receipts regardless of how you pay. You're responsible for ensuring your withdrawals are for IRS-approved expenses. You'll need your receipts to verify your expenses were eligible if you're ever audited by the IRS. The IRS may require documentation to show the money was used for qualified expenses. Be sure your receipts have all of these details:

- Date of service or purchase
- Name of patient
- Name and address of the provider or merchant
- Description of the service provided or product purchased
- Patient portion or amount owed

Health care debit card or credit card receipts, non-itemized cash register receipts, and canceled checks are insufficient. Please be sure you have a doctor's prescription for any over-the-counter medicines you purchase, as the eligibility of over-the-counter items depends on whether you have a prescription. For updated information, visit OptumFinancial.com if you are an Anthem member or have waived PG&E-sponsored medical coverage, or visit kp.org/healthpayment if you are a Kaiser member.

If requested by Optum Financial or Kaiser Health Payment Services, please be sure to provide your health care debit card receipts within the time frame requested. Otherwise, your payment or swipe transaction will be deemed ineligible and you will be required to refund the amount of transaction. If you fail to reimburse your account, the total amount of the ineligible expenses may be added to your W-2 as taxable income.

Remember to verify your expenses: Optum or Kaiser will send multiple reminders if you need to verify expenses. You'll have 180 days to verify your expenses. After 180 days, if you haven't verified expenses and they total more than $150, your card may be suspended.

Deadline for Submitting Health Care Flexible Spending Account Claims and Receipts

You can submit claims for eligible expenses incurred during the year, as well as any required supporting documentation, by June 30 of the following year.

Getting reimbursed	Health Care Flexible Spending Account (HCFSA)	Health Account
What's the latest you can file a claim?	June 30 for expenses incurred through December 31 of the prior year	No deadline for active participants
Can you use your health payment card?	Yes, for current-year expenses No, for prior-year expenses	Yes, for current-year expenses No, for prior-year expenses
If your health payment card administrator requests more information – what's the latest you can verify your expense?	June 30 for expenses incurred through December 31 of the prior year	180 days*

* Your health payment card administrator will send multiple reminders if you need to verify expenses. You'll have 180 days to verify your expenses. After 180 days, if you haven't verified expenses and they total more than $150, your card will be suspended.

In general, any amounts remaining in the HCFSA after June 30 of the following year will be forfeited. However, you can carry over unused balances up to a certain amount as long as you are eligible to participate in the HCFSA as of January 1 of the next year. Visit mypgebenefits.com > Financial Health > Spending Accounts > for more information.

Dependent Care Flexible Spending Account (DCFSA)

You use the money in your DCFSA to "pay" for eligible dependent care expenses. When you obtain services that are eligible for reimbursement, you "withdraw" the money from your DCFSA.

You may pay for out-of-pocket expenses using your own personal credit card, cash or check, and keep your itemized receipt as supporting documentation. Then, log in to your online account to file for reimbursement. Or, instead of paying upfront out of your own pocket, you may pay your provider by requesting that your FSA Administrator remit payment from your FSA directly to the provider, whose name you indicate as the payee. You must file all dependent care claims through this manual claim process.

You may pay for the expense prior to submitting your claim for reimbursement, although it is not necessary to do so. Nevertheless, you are responsible for paying all invoices on time, regardless of when you receive your reimbursement.

If you are an Anthem member or you have waived PG&E-sponsored medical coverage	If you are a Kaiser member
▪ Go to the Benefits Portal and click on the Optum Financial link. ▪ Once logged on, you can easily access your account balance or enter a new claim. Your account details are available at any time online, or over the phone at 1-866-271-8144.	▪ Go to kp.org/healthpayment. ▪ Once logged on, you can easily access your account balance or enter a new claim. Your account details are available at any time online, or over the phone at 1-877-750-3399.

If you need help determining which of your expenses are eligible, you should contact Optum Financial or Kaiser Health Payment Services, as applicable. Eligibility for reimbursement is based on when services are actually received, regardless of when you pay for such expenses. See "Eligible Expenses" for further details.

You can print and mail the completed claim submission form, along with original invoices or receipts to Optum Financial or Kaiser Health Payment Services. Be sure to keep a photocopy of everything for yourself before you submit it to Optum Financial or Kaiser Health Payment Services. Or you may fax your completed claims submission form and a copy of the original invoice to your FSA administrator at the fax number below. Save a copy of your fax confirmation receipt as proof of successful submission.

If you are an Anthem member or you have waived PG&E-sponsored medical coverage, submit documentation to:	If you are a Kaiser member, submit documentation to:
Optum Financial Claims Administrator P.O. Box 622317 Orlando, FL 32862-2317 Fax number: 443-681-4602 OptumFinancial.com	Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540 Fax number: 1-877-535-0821 kp.org/healthpayment **email: kp@healthaccountservices.com**

Processing of Claims

If you are in the Anthem HAP or have waived PG&E-sponsored medical coverage, after your claim is processed, you'll receive a reimbursement check mailed to your home, or you can elect direct deposit at OptumFinancial.com. Reimbursement checks issued and not cashed within six months of issuance will be

considered forfeitures. If you choose automatic deposit for your FSA reimbursements for any calendar year, the election will automatically roll over when you re-enroll in the Plan for a future calendar year.

If you are a Kaiser member, log in to kp.org/healthpayment.

Always Save Your Itemized Receipts

Always save your itemized receipts regardless of how you pay. The IRS may require documentation to show the money was used for qualified expenses. Be sure your receipts have all of these details:

- Date of service
- Dependent's name
- Service provider's name
- Service provider's tax ID (or Social Security number if the provider is not registered or licensed with the state, even if the provider is someone such as your neighbor)
- Description of the service
- Amount charged

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

Deadline for Submitting Dependent Care Claims and Supporting Documentation

For the DCFSA, in general, any unused balance amount will be forfeited at the end of the plan year. However, you have until March 15 of the following year to incur eligible dependent care expenses against contributions made in the current year – this is called a "grace period". You then have until June 30 of that year to file claims, as well as any required supporting documentation, for eligible expenses incurred through the grace period.

Visit mypgebenefits.com > Financial Health > Spending Accounts > for more information.

When Reimbursements Are Available

For DCFSA claims, the amount of the reimbursement will depend upon how much money is in your account. You will be reimbursed in full for your incurred eligible expenses, provided your account balance is equal to or greater than the amount of your claim. If your account balance is less than the amount of your claim, you will receive partial reimbursement for your claim. The remainder of your claim will be automatically paid during the next processing cycle or after sufficient funds are deposited in your account.

Flexible Spending Account (FSA) Limitations

Flexible spending accounts (FSAs) are governed by IRS regulations. When you are deciding on the amounts you want to allocate to each account, you should keep in mind these regulations and limitations:

- Once you have decided on your annual contribution amount, you cannot change the amount you contribute during the year unless you have an eligible mid-year election change event through marriage, divorce, etc. See "Mid-Year Election Change Events" for important requirements and deadlines regarding mid-year election change events.
- If you have both an HCFSA and a DCFSA, you cannot transfer money between your two accounts.
- With the exception of the carry over amount (for HCFSAs) and the grace period (for DCFSAs), you will forfeit any amounts in your FSAs that are not used for expenses incurred during the plan year and timely submitted for reimbursement by June 30 of the following plan year.

The forfeiture of unused dollars is the reason why it is imperative that you estimate your costs carefully before deciding on your annual FSA contributions.

What this means to you

If you have funds left in your HCFSA at the end of the year, you will automatically carry over to the next year the unused balance up to a certain amount as long as you are eligible to participate in the HCFSA as of January 1 of the next year.

When will my carry-over FSA dollars be available?

You have until June 30 of the following plan year to submit claims for eligible expenses incurred in the prior plan year. After all prior year claims have been processed, your remaining balance, up to the carry over amount, will automatically carry over into an HCFSA and be available to pay for eligible health care expenses incurred in the new plan year.

Questions About Claims for Reimbursement

You should refer any questions about your claims for reimbursement to the Claims Administrator: Optum Financial if you are an Anthem member or have waived PG&E-sponsored medical coverage, or Kaiser Health Payment Services if you are a Kaiser member. If you have questions after reviewing the website, please contact Optum Financial or Kaiser Health Payment Services, as applicable.

If you are an Anthem member or you have waived PG&E-sponsored medical coverage:	If you are a Kaiser member:
Optum Financial 1-866-271-8144 Service hours: 5 a.m. to 5 p.m., Pacific time, Monday through Friday	Kaiser Health Payment Services 1-877-750-3399 Service hours: 5 a.m. to 7 p.m., Pacific time; Monday through Friday
Mailing address:	Mailing address:
Optum Financial Claims Department P.O. Box 622317 Orlando, FL 32862-2317	Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540
OptumFinancial.com	kp.org/healthpayment **email: kp@healthaccountservices.com**

Health Care Flexible Spending Account (HCFSA)

Eligible Expenses

You can use your HCFSA to pay for eligible tax-deductible health care expenses for yourself and your eligible dependents.

"Eligible Dependents" Defined

Your eligible dependents are individuals who qualify as your tax dependents under Internal Revenue Code section 105(b). Many registered domestic partners do not qualify as your tax dependents for this purpose.

You can use your Health Account to pay for Qualifying Health Care Expenses. These are expenses incurred by you, or by your eligible dependent, for medical care as defined in Internal Revenue Code sections 213(d) or 106(f). Qualifying Health Care Expenses do not include expenses that are reimbursed or otherwise covered by a medical plan, medical insurance, or otherwise, nor do they include health insurance premiums or premiums for long-term care insurance or long-term care services.

Many health care expenses not covered or not paid in full by a health care plan, including deductibles, copayments, coinsurance or other out-of-pocket expenses, such as for prescription drugs and out-of-network services, are eligible expenses. To be eligible for reimbursement, the expense must be incurred during the

coverage period (generally, the period in which you have contributed to an HCFSA for a year, except with respect to any amounts carried over to the next year). If you begin contributing mid-year, for example, due to an eligible mid-year change event, expenses incurred before you began participating in the HCFSA.

Contact your FSA Claims Administrator if you need further information about which expenses are reimbursable.

Ineligible Expenses

You cannot use your HCFSA for any expenses that are paid for by any other medical, dental or vision plans, not considered tax-deductible by the IRS, or not considered an eligible health care item.

Partial Prepayments

Many medical treatment programs span several plan years. For example, prenatal care, orthodontia or fertility treatment programs may take two or more years. Reimbursement of the entire expense "up-front" violates the "expense incurred" requirement. In the case of orthodontics, the orthodontist allocates service expenses over the course of the treatment plan. Payments you make for treatment received in the current calendar year are eligible for reimbursement from your account for the same calendar year. If you have questions about how claims for ongoing treatment programs will be reimbursed, contact Optum Financial at **1-866-271-8144** or visit OptumFinancial.com if you are an Anthem member or have waived PG&E-sponsored medical coverage, or Kaiser Health Payment Services at **1-877-750-3399** or kp.org/healthpayment if you are a Kaiser member.

Claims and Appeals

If Eligibility Is Denied

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

If you are not satisfied with the outcome of your contact with the PG&E Benefits Service Center, you may file an eligibility claim by writing to:

Pacific Gas and Electric Company
Benefits Department
Health Plan Claims
300 Lakeside Drive
Oakland, CA 94612

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

Eligibility Appeals

If you are not satisfied with the Benefit Department's decision on your claim, you may then submit a written appeal for review (within 60 days of receiving the Benefits Department's notice of denial) to the Employee Benefit Appeals Committee (EBAC), the final decision maker in the appeals process, stating the reasons for your appeal and enclosing all documentation and any additional information to support your appeal.

No special form or format is required in submitting a written appeal; you may submit written comments, documents, records, and other information relating to your appeal. You may also request, free of charge, access to, or copies of, all documents, records, and other information relevant to your appeal for benefits. The review will take into account all comments, documents, records, and other information submitted by you relating to your appeal, without regard to whether such information was submitted or considered at the initial benefit determination.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department – EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

You will receive a final ruling from the EBAC within 60 days of the EBAC's receipt of your appeal unless, due to special circumstances, the EBAC requires additional time to respond, up to another 60 days.

Health Care Flexible Spending Account Claims

If a Health Care Flexible Spending Account (HCFSA) claim you submit is denied in part or whole, Optum Financial or Kaiser Health Payment Services, as the Claims Administrator, will provide you with written notice within 30 days of receiving your claim. In certain cases, an additional 15 days may be required by the Claims Administrator to respond to you. If an extension is required, you will be notified of this extension within the initial 30 days from the date on which the Claims Administrator received your claim.

Send your claims to:

If you are an Anthem member or you have waived PG&E-sponsored medical coverage:	If you are a Kaiser member:
Optum Financial Claims Department P.O. Box 622317 Orlando, FL 32862-2317	Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540

If Optum Financial or Kaiser Health Payment Services needs additional information from you, you will be given 45 days from the receipt of this notice to provide the additional information. In this case, the Claims Administrator will respond in writing within 15 days after receiving your additional information.

If your claim is denied, the denial letter will include:

- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the determination is based;
- a description of any additional material or information needed to perfect your claim and an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them, including your right to bring a civil action under Section 502(a) of ERISA following a final appeal;
- a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination or a statement that a copy of any such rule, guideline, protocol or other similar criterion will be provided, free of charge, upon request; and
- an explanation of any scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or a statement that the explanation will be provided, free of charge, upon request.

Health Care Flexible Spending Account (HCFSA) Appeals

If you believe the initial determination denies you a Health Care Flexible Spending Account (HCFSA) benefit to which you may be entitled, you may appeal to the Plan Administrator.

Send your appeal to:

If you are an Anthem member or you have waived PG&E-sponsored medical coverage:	If you are a Kaiser member:
Optum Financial Claims Department P.O. Box 622317 Orlando, FL 32862-2317 Fax number: 443-681-4602	Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540

This appeal must be made in writing within 180 days after receiving written notice of the denial from Optum Financial if you are an Anthem member or have waived PG&E-sponsored medical coverage, or from Kaiser Health Payment Services if you are a Kaiser member. The appeal must contain the following information:

- The reason(s) for making the appeal;
- The facts supporting the appeal;
- The amount claimed; and
- The name and address of the person filing the appeal (claimant).

To expedite processing, you should also include an AUTHORIZATION TO USE AND/OR DISCLOSE PERSONAL HEALTH INFORMATION form. You can access a copy online at mypgebenefits.com > Resources > Legal Notices or by calling the PG&E Benefits Service Center at **1-866-271-8144**.

Optum Financial or Kaiser Health Payment Services will generally make a decision within 60 days after receiving the appeal and mail or email a copy of the decision to you promptly (non-receipt of the Authorization form may delay your appeal). The decision will either overrule or uphold the Plan Administrator's earlier determination, based on plan parameters and guidelines received from PG&E. If your appeal is denied, the denial letter will include:

- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- a statement regarding your right to bring a civil action under Section 502(a) of ERISA following a final appeal;
- a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination or a statement that a copy of any such rule, guideline, protocol or other similar criterion will be provided, free of charge, upon request; and
- an explanation of any scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or a statement that the explanation will be provided, free of charge, upon request.

PG&E's Voluntary Claims and Appeals Review Process

If you are not satisfied with the claims and appeals review process completed with Optum Financial or Kaiser Health Payment Services, as applicable, you may elect to use PG&E's Voluntary Claims and Appeals Review Process, as described below, or elect to bring a civil action. You have 90 days from the date of receipt of the final decision from Optum Financial or Kaiser Health Payment Services to elect this claims and appeals review process. Initiation of the Voluntary Claims and Appeals Review Process does not restrict your ability to bring a civil action against the Plan.

The first step of the Voluntary Claims and Appeals Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include an AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PERSONAL HEALTH INFORMATION form. You can access a copy online at mypgebenefits.com > Resources > Legal Notices.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
Appeals
300 Lakeside Drive
Oakland, CA 94612

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the Authorization form may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

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

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

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

- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under Section 502(a) of ERISA.

Dependent Care Flexible Spending Account (DCFSA)

The Dependent Care Flexible Spending Account (DCFSA) helps you pay for dependent care so you can work.

The DCFSA is not for your dependents' health care. It is for expenses associated with your dependents' care such as day care or elder care.

Whose Expenses Are Eligible?

You can reimburse eligible expenses that are incurred on behalf of a person who meets the requirements to be a DCFSA Dependent. The definition of DCFSA Dependent may differ from the one used in determining your personal income taxes and from the definition used to determine whose expenses may be reimbursed from your HCFSA A DCFSA Dependent is:

- a person under age 13 who is your qualifying child under the Internal Revenue Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);

- your spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or
- a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition).

Note that, under a special rule for children of divorced or separated parents, a child is a DCFSA Dependent with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child.

Eligible Expenses

You can use your Dependent Care Flexible Spending Account (DCFSA) to pay for eligible dependent care expenses on a tax-free basis. To qualify as an eligible expense, the care must be provided for your DCFSA Dependent(s) so that you can work (if you're married your spouse also must work, be looking for work, or attend school full time). Refer to the IRS Publication 503, Child and Dependent Care Expenses available at irs.gov), or consult with a tax advisor for more details on allowable expenses.

To be eligible, the expenses must be incurred during the period in which you actually made the contributions to your DCFSA. If you begin contributing mid-year, expenses incurred before you began contributing are not eligible.

If all applicable requirements are satisfied, eligible DCFSA expenses may include:

- costs of care provided outside your home if the care is for your dependent under age 13 or any other qualifying person who regularly spends at least 8 hours each day in your home;
- services of a day-care center, nursery school or preschool (but not kindergarten) if the center complies with all state and local laws;
- summer day camps.

Ineligible Expenses

The IRS does not allow charges for the following:

- Expenses for an individual that does not meet the requirements outlined under "Whose Expenses Are Eligible?"
- Expenses incurred for day care services received while you or your spouse are on a leave of absence
- Sports camps and overnight camps for children under age 13, with the exception of summer day camp if a child is not in school and the camp is used as day care

Please note that this is only a sampling of eligible and ineligible expenses. You should refer to IRS Publication 503, Child and Dependent Care Expenses, available from your local IRS office (or the IRS website at irs.gov), or consult with a tax advisor for more details on allowable expenses.

Tax Credit

The Dependent Care Flexible Spending Account (DCFSA) is one way to reduce your tax liability if you pay dependent care expenses. The Federal Dependent Care Income Tax Credit can also help you lower your income tax liability. Please consult with your tax advisor to obtain more information on the Federal Dependent Care Income Tax Credit and to determine which method or combination of the DCFSA and the Federal Dependent Care

Income Tax Credit offers the greatest tax savings for your particular situation. You may also refer to IRS Publication No. 503 (Child and Dependent Care Expenses).

If Eligibility Is Denied

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

If you are not satisfied with the outcome of your contact with the PG&E Benefits Service Center, you may file an eligibility claim by writing to:

Pacific Gas and Electric Company
Benefits Department
Health Plan Claims
300 Lakeside Drive
Oakland, CA 94612

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

Eligibility Appeals

If you are not satisfied with the Benefit Department's decision on your claim, you may then submit a written appeal for review (within 60 days of receiving the Benefits Department's notice of denial) to the Employee Benefit Appeals Committee (EBAC), the final decision maker in the appeals process, stating the reasons for your appeal and enclosing all documentation and any additional information to support your appeal.

No special form or format is required in submitting a written appeal; you may submit written comments, documents, records, and other information relating to your appeal. You may also request, free of charge, access to, or copies of, all documents, records, and other information relevant to your appeal for benefits. The review will take into account all comments, documents, records, and other information submitted by you relating to your appeal, without regard to whether such information was submitted or considered at the initial benefit determination.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department – EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

You will receive a final ruling from the EBAC within 60 days of the EBAC's receipt of your appeal unless, due to special circumstances, the EBAC requires additional time to respond, up to another 60 days.

Dependent Care Flexible Spending Account (DCFSA) Claims

If a Dependent Care Flexible Spending Account (DCFSA) claim you submit is denied in part or whole, Optum Financial or Kaiser Health Payment Services, as the Claims Administrator, will notify you within 60 days of their receiving your claim, with an explanation of why the claim was denied and any materials you could submit that would reverse the denial or perfect the claim.

Send your claims to:

If you are an Anthem member or you have waived PG&E-sponsored medical coverage:	If you are a Kaiser member:
Optum Financial Claims Department P.O. Box 622317 Orlando, FL 32862-2317	Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540

Dependent Care Flexible Spending Account (DCFSA) Appeals

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

Send your first appeal to:

If you are an Anthem member or you have waived PG&E-sponsored medical coverage:	If you are a Kaiser member :
Optum Financial Claims Department P.O. Box 622317 Orlando, FL 32862-2317 Fax number: 443-681-4602	Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540

This appeal must be made in writing within 180 days after receiving written notice of the denial from Optum Financial if you are an Anthem member or have waived PG&E-sponsored medical coverage, or from Kaiser Health Payment Services if you are a Kaiser member, and must contain the following information:

- The reason(s) for making the appeal;
- The facts supporting the appeal;
- The amount claimed; and
- The name and address of the person filing the appeal (claimant).

To expedite processing, you should also include an AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PERSONAL HEALTH INFORMATION form. You can access a copy online at mypgebenefits.com (select Resources > Legal Notices, or by calling the PG&E Benefits Service Center at **1-866-271-8144**.

Optum Financial or Kaiser Health Payment Services will generally make a decision within 60 days after receiving the appeal (non-receipt of the Authorization form may delay your appeal) and mail or email a copy of the decision to you promptly. The decision will either overrule or uphold the Plan Administrator's earlier determination, based on plan parameters and guidelines received from PG&E. The decision will give specific reasons and references to the HCFSA Plan provisions which support Optum Financial or Kaiser Health Payment Service's decision.

PG&E's Voluntary Claims and Review Process

If you are not satisfied with the claims and appeals review process completed with Optum Financial or Kaiser, as applicable, you may elect to use PG&E's Voluntary Claims and Appeals Review Process, as described below. You have 90 days from the date of receipt of the final decision from Optum Financial or Kaiser to elect this claims and appeals review process.

The first step of the Voluntary Claims and Appeals Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include an AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PERSONAL HEALTH INFORMATION form. You can access a copy online at mypgebenefits.com (select Resources > Legal Notices, or by calling the PG&E Benefits Service Center at **1-866-271-8144**.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
Appeals
300 Lakeside Drive
Oakland, CA 94612

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the Authorization form may delay your appeal). There may be special circumstances where an extension of up to an additional 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

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

You may then have your appeal reviewed by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information supporting your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

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

- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based; and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Leave and Disability

In general, all regular-status full-time and part-time employees of the Company are eligible for the company-sponsored sick pay and disability plans described in this section. Hiring hall employees and non-regular status employees are not eligible for the Company-sponsored benefits described in this section but are eligible for the legislative benefits as described. Contract employees and agency workers are not eligible for the benefits described in this section.

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company.

Except as otherwise provided, benefits in this section are not subject to ERISA.

Resources to Help You Stay At or Return to Work

Pursuant to the federal Americans with Disabilities Act Amendments Act (ADAAA) and the California Fair Employment and Housing Act (FEHA), if you are an eligible employee and need assistance to perform one or more essential functions of your job, you may request a reasonable accommodation. When a request for reasonable accommodation is received, the company will engage in the interactive process, which includes a discussion with the employee requesting the accommodation, the supervisor, and the Return to Work Consultant, to determine how the requested accommodation, or a comparable accommodation, can be provided.

A reasonable accommodation is defined as the removal of a workplace barrier and would include any modification or adjustment to a job, employment practice or work environment that allows the eligible employee to perform the essential functions of the job and is not considered burdensome to a company.

Each accommodation request is reviewed and analyzed on a case-by-case basis to determine eligibility, effectiveness and reasonability of the accommodation in enabling the individual to perform the essential functions of his or her job. While the employee's accommodation preference will be considered during the interactive process, the company may offer an alternate accommodation if it removes the barrier and allows the employee to perform the essential functions of the job.

If you need to request a reasonable accommodation, you should discuss it with your supervisor and/or contact the Stay at Work/Return to Work Team. Additional information can be reviewed on mypgebenefits.com (select Time Off and Accommodations > Workplace Accommodations and Internal Job Search Program).

If you're choosing to breastfeed or chestfeed, and you need an accommodation to express milk during working hours, learn more about PG&E's Lactation Rooms at work by visiting mypgebenefits.com > Mental Health and Family Support > Lactation Rooms at Work or review the Lactation Room Standard (HR-1161S).

Additional Information

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

Plan Documents and Administration

The plan documents and the most recent group short- and long-term disability plans and/or policies contain the detailed provisions of the plans. Where applicable, the plan documents incorporate the terms of this Summary of Benefits Handbook as well as any applicable Summaries of Material Modifications and insurance policies.

Unless otherwise noted, if there is a conflict between a plan document and this Summary of Benefits Handbook, the plan document controls. However, with respect to fully insured benefits, the terms of the certificate of insurance or other similar document control when describing specific benefits that are covered or insurance-related terms.

The Employee Benefit Committee of PG&E Corporation has the discretionary authority to interpret and construe the terms of the plan, to resolve any conflicts or discrepancies between documents and to establish rules which are necessary or desirable for the administration of the plan. Notwithstanding the foregoing, the relevant insurer has the authority to construe and interpret the terms of the certificate of insurance or other similar document.

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The Coverage Available

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

- Company-sponsored benefits,
- Legislated benefits, and
- Workers' Compensation Supplemental Benefits.

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

The Pacific Gas and Electric Company Benefits	Legislated Plans
▪ Sick Pay ▪ Short-Term Disability (STD) Benefits(for ESC-represented employees only) ▪ Long-Term Disability (LTD) ▪ Supplemental Benefits for Industrial Injury	▪ Sick Leave under California Healthy Workplaces, Healthy Families Act ▪ PG&E's Voluntary Disability and Paid Family Leave Benefit Plan (VPDI) ▪ California State Disability Insurance (SDI) ▪ Workers' Compensation

Please refer to *Time Off and Leaves* for information on Parental Leave benefits.

Company-Sponsored Plans

- **Sick Leave for IBEW- and SEIU-represented employees:** Provides continuation of your full salary for periods of illness or non-work-related injury based on annual sick leave awards and how much unused sick leave you have accumulated from past years.
- **Incidental and Capped Sick Time for ESC-represented employees:** The Sick Time policies for ESC-represented employees provide continuation of your full salary for periods of non-work-related illness or injury based on monthly sick time accruals, for eligible employees, and the amount of available sick leave converted to a Capped Sick Time Bank.
- **Short-Term Disability (STD) for ESC-represented employees:** The PG&E STD policy is comprised of three components, Capped Sick time, Voluntary Plan Disability Insurance (VPDI) and STD Wage Continuation Benefits, and provides employees with income replacement when unable to work because of a non-work-related illness or injury for more than seven calendar days. Capped Sick time provides full income replacement and STD Wage Continuation supplements VPDI to provide income replacement for up to 70% net of an employee's weekly basic wage rate prior to disability. For information about PG&E's Paid Family Leave (PFL) policy, please see *Time Off and Leaves.*
- **Long-Term Disability (LTD)** — Provides you with income replacement if you become disabled because of an accident or a long-term illness and you are unable to work. There are four different plans under which you may qualify for LTD benefits. The plan for which you may qualify depends upon when you become eligible for LTD benefits and/or when the onset of your disability started. Detailed information for each of these plans is provided under "Long-Term Disability (LTD) Plan."
  - Plan I: For eligible employees who became eligible for LTD benefits prior to January 1, 2000.
  - Plan II: For eligible employees who became eligible for LTD benefits on or after January 1, 2000, and the onset of your disability was prior to:
    - June 1, 2003 (if IBEW Clerical-, ESC- or SEIU-represented), or
    - October 1, 2003 (if IBEW Physical-represented).
  - Plan III: For eligible employees who became eligible for LTD benefits on or after:

- June 1, 2003 (if IBEW Clerical- or SEIU-represented) and the onset of your disability was prior to January 1, 2018,
- June 1, 2003, (if ESC-represented), and the onset of your disability was prior to January 1, 2017, or
- October 1, 2003 (if IBEW Physical-represented) and the onset of your disability was prior to January 1, 2018.

▫ Plan IV: For eligible employees whose onset of disability was on or after January 1, 2017:

- January 1, 2017 (if ESC-represented), or
- January 1, 2018 (if IBEW- or SEIU-represented).

- **Supplemental Benefits for Industrial Injury** — The Company pays a supplemental benefit, above Workers' Compensation disability income, if you sustain an occupational injury or illness on the job and are entitled to Workers' Compensation temporary disability benefits.

Legislated Plans

The following benefits are paid in compliance with federal and state law:

- **Sick Leave under California Healthy Workplaces, Healthy Families Act** for temporary additional employees or intermittent employees who have not attained regular status – Provides continuation of your full salary for periods of illness or non-work-related injury. Eligible employees receive 40 hours* (five days) of sick leave with pay, immediately upon employment, which you can start using after ninety (90) cumulative days of employment. *Note: only SEIU eligible.
- **PG&E's Voluntary Disability and Paid Family Leave Benefit Plan ("Voluntary Plan" or "VP")** — PG&E's Voluntary Plan pays a temporary weekly income benefit for illness or injury, to care for a seriously ill family member, to bond with a new child, or to participate in a qualifying exigency related to the covered active duty or call to covered active duty of an employee's spouse, domestic partner, child, or parent in the Armed Forces of the U.S., and is offered in lieu of California State Disability Insurance.
- **California State Disability Insurance (SDI)** — The State of California pays a temporary weekly income benefit for illness or injury or to care for a seriously ill family member, to bond with a new child, or to participate in a qualifying exigency related to the covered active duty or call to covered active duty of an employee's spouse, domestic partner, child, or parent in the Armed Forces of the U.S
- **Workers' Compensation** — The Company pays benefits for occupational injury or illness.

Eligibility, Enrollment and Cost

Eligibility

In general, all regular full-time and part-time employees are eligible for the Company-sponsored Sick and Disability policies described in this section.

You are not eligible for benefits under the Company-sponsored Sick and Disability policies if you are a contract or agency worker, a hiring hall employee, or a temporary additional or intermittent employee who has not attained regular status. Temporary additional or non-regular-status intermittent employees should refer to "Sick Leave for Temporary Additional or Intermittent Employees Who Have Not Attained Regular Status" o for details on the Sick pay benefits for which you are eligible. Hiring hall employees should refer to the Summary of Benefits Handbook for Hiring Hall Employees for details on the Sick Leave policy for Hiring Hall employees.

Company-Sponsored Benefits

Sick Time for ESC-Represented Employees

In general, full-time ESC-represented employees are eligible for the Incidental Sick Time Policy described in this section (see "Incidental and Capped Sick Time Upon Termination (ESC-Represented Employees)"). In addition,

ESC-represented employees hired prior to 2017 who had previously accrued "regular/accumulated" Sick Leave hours on record as of December 31, 2016, were eligible to have the remaining "regular" Sick Leave hours converted into a "Capped Sick Time Bank" on January 1, 2017. See "Capped Sick Time Bank Conversion Upon Retirement (ESC-Represented Employees)" .

Part-time or regular-status intermittent ESC-represented employees are generally eligible for a prorated share of Incidental Sick Time. If you also were eligible for a Capped Sick Time Bank, there was no proration of remaining "regular/accumulated" Sick Leave hours prior to the hours being converted to a Capped Sick Time Bank.

Sick Pay for IBEW- and SEIU-Represented Employees

In general, regular-status full-time IBEW- and SEIU-represented employees are eligible for the Sick Pay Policy described in this section after completing one year of service. In general, regular-status part-time or intermittent IBEW- or SEIU-represented employees are eligible for a prorated share of Sick Pay benefits after completing one year of service. See "Sick Leave for IBEW- and SEIU-Represented Employees."

Short-Term Disability (for ESC-represented employees only)

ESC-represented employees are eligible for the Short-Term Disability (STD) Policy. Employees must be covered under the Voluntary Plan to be eligible for supplemental STD benefits. See "Short-Term Disability (STD) Policy for ESC-Represented Employees" .

Long-Term Disability

All regular-status full-time, part-time and intermittent employees are automatically covered by the Long-Term Disability (LTD) Plan on the first day of the month following attainment of regular status. See "Long-Term Disability (LTD) Plan."

Legislated Plans

PG&E Voluntary Disability and Paid Family Leave Benefit Plan (Voluntary Plan)

All Utility employees who work in California are automatically enrolled in Pacific Gas and Electric Company's (PG&E's) Voluntary Disability and Paid Family Benefit Plan (Voluntary Plan) upon hire, unless you choose to opt-out and be covered under the California State Disability Insurance and Paid Family Leave Plan (State Plan). Please visit the Voluntary Plan page on mypgebenefits.com for additional information on benefit eligibility. Contract and agency employees who work in California are not eligible for PG&E's Voluntary Plan coverage.

PG&E's Voluntary Plan is administered by the Company's Leave and Disability Administrator and funded by employee contributions which are automatically deducted from the paychecks of all California-based employees who participate in the Voluntary Plan.

Employees who choose to opt out of PG&E's Voluntary Plan may do so by contacting the PG&E Benefits Service Center.

California State Disability Insurance and Paid Family Leave Plan (State Plan)

Employees who work in California and choose to opt-out of PG&E's Voluntary Plan or who are ineligible for the Plan will be automatically enrolled in the State Plan. Please visit the State's website at edd.ca.gov for additional information on State Plan benefit eligibility.

The State Plan is administered by the State of California and funded by employee contributions which are automatically deducted from the paychecks of employees who are enrolled in the State Plan.

Workers' Compensation

All employees are eligible for Workers' Compensation benefits upon hire.

PG&E Supplemental Benefits

Supplemental Benefits for Industrial Injury Plan

Injured workers who qualify for Workers' Compensation benefits may also qualify for payments under the Supplemental Benefits for Industrial Injury Plan. See "Workers' Compensation" and "Supplemental Benefits for Industrial Injury Plan."

Enrollment

When you meet the eligibility requirements, you are automatically covered by all of the sick pay and disability coverages, as described in this section.

Cost of Coverage

The Company pays the full cost of benefits provided under the Sick Pay policies, the Short-Term Disability (STD) Wage Continuation policy (for ESC-represented employees only), the Long-Term Disability Plan, Workers' Compensation and the Supplemental Benefits for Industrial Injury Plan. You pay for the cost of coverage for the Voluntary Plan or the State Plan, as applicable, through payroll deductions.

Sick Time Policies for ESC-Represented Employees

NOTE: if you are an IBEW- or SEIU-represented employee, see "Sick Leave for IBEW- and SEIU-Represented Employees."

The Sick Time policy applies whether you have opted into the Voluntary Plan or have chosen to be covered under the State Plan and provides continued pay when you are temporarily unable to work because of an illness or injury that does not qualify as an industrial injury under the terms of Workers' Compensation.

There are two Sick Time policies – Incidental Sick Time and Capped Sick Time – for ESC-represented employees.

The use of Incidental or Capped Sick Time does not extend the maximum period of leave to which an employee may be entitled under the California Family Rights Act (CFRA), the Family and Medical Leave Act (FMLA), the California Pregnancy Disability Leave (PDL) or any similar local or state leave law.

The Sick Time policy is a payroll practice not subject to ERISA.

Eligibility and more information on sick leave covered under local city ordinances (e.g., Berkeley, Oakland, and San Francisco) can be found in the Time Off and Accommodations section on mypgebenefits.com and your respective collective bargaining agreement.

Incidental Sick Time for ESC-Represented Employees

ESC-represented employees, including full-time, part-time and regular-status intermittent employees, are generally eligible for the Incidental Sick Time provisions explained in this section. Part-time and regular-status intermittent employees are eligible for a prorated share of Incidental Sick Time benefits, based on the employee's part-time work schedule.

You may use Incidental Sick Time for your own non-work-related illness or injury, medical appointments for preventive care or the diagnosis, care or treatment of an existing health condition, or for specified purposes if you or a family member are a victim of a qualifying act of violence. A portion of your Incidental Sick Time can also be used to care for an eligible family member, as described later in the Family Sick Leave section.

It may be appropriate to use Incidental Sick Time for absences of seven calendar days or less (including during the waiting period, if your leave of absence has a waiting period, for Short-Term Disability benefits). For absences beyond seven calendar days, you must apply for STD benefits with the Leave and Disability Administrator, and your absence must be supported by medical certification and meet the definition of "disabled" under the Short-Term Disability policy. If you have Capped Sick Time and Incidental Sick Time, Incidental Sick Time will be used first and exhausted. Capped Sick Time will be used afterwards. If you are on an FMLA, CFRA, or PDL covered leave and are eligible for STD benefits, you may elect not to use your sick time after the waiting period.

For certain qualifying absences lasting less than seven calendar days, where the STD waiting period does not apply, for your own medical condition, unless you elect otherwise, your Incidental Sick Time Bank will be exhausted prior to using Capped Sick Time. Sick time must be used and exhausted prior to using vacation pay, floating holidays or being unpaid, including when taking time off on an intermittent approved leave of absence.

While you may not be eligible for Short-Term Disability based on your length of absence, you may still qualify for a leave of absence when using your Incidental Sick Time. In these cases, you need to follow the leave of absence process. For example, if you are off work for a serious health condition, including if you have a chronic condition for which a leave may be needed intermittently, you will need to follow the leave of absence process and contact the Leave and Disability Administrator. Your Incidental Sick Time will run concurrently with your leave of absence, when applicable, and will not extend the amount of leave you may be eligible for under federal, state or local leave laws. Please refer to *Time Off and Leaves*.

If you are unsure if your absence qualifies for a leave of absence or Short-Term Disability, please follow the leave of absence process and contact the Leave and Disability Administrator to determine eligibility.

Accruing Incidental Sick Time

Full-Time Employees

Full-time employees hired will receive eight hours of Incidental Sick Time immediately upon hire. Incidental Sick Time hours will accrue Incidental Sick Time at the rate of eight hours per month, to be credited on the first calendar day of each month, provided that the maximum allowed accrual limit has not been met. The maximum number of hours you can accumulate in your Incidental Sick Time Bank at any one time is 96 hours.

At the end of each month, any unused Incidental Sick Time carries over to the following month, up to the maximum allowed limit of 96 hours. If, at the end of each month, the balance of your Incidental Sick Time Bank is below the maximum of 96 hours, then you'll accrue up to eight additional hours of Incidental Sick Time on the first calendar day of the following month. However, in no event will you accrue Incidental Sick Time so that your bank exceeds 96 hours.

Example 1: Incidental Sick Time Accrual for Full-Time Employee

Lucy was hired on April 6, 2016. As a full-time employee hired before 2017, Lucy qualified to receive the special one-time award of 96 hours of Incidental Sick Time on January 1, 2017. Her monthly accrual rate will be eight (8) hours, and her maximum allowed accrual limit will be 96 hours.

Lucy does not use any Incidental Sick Time in January or February of 2017. She is therefore not eligible to accrue any additional sick hours in February or March of 2017, since she still has the maximum allowed accrual limit of 96 hours in her Incident al Sick Time Bank.

In March 2017, Lucy takes 16 hours of Incidental Sick Time so that, as of the end of March, her Incidental Sick Time Bank has dropped to 80 hours. Because she is now under the 96-hour maximum limit, Lucy will start accruing Incidental Sick Leave and will receive eight additional hours on April 1. With the addition of these eight hours, her new Incidental Sick Time balance on April 1 will be 88 hours.

If Lucy does not use any Incidental Sick Leave during April, at the end of the month, she will have a balance of 88 hours in her sick bank. Because Lucy's Incidental Sick Time Bank will be under the 96-hour maximum limit at the end of April, she will accrue an additional eight hours on May 1. This eight-hour award will bring her back up to the maximum allowed accrual limit of 96 hours. If Lucy does not take any Incidental Sick Time in May, she will remain at the maximum limit of 96 hours. She therefore would not accrue any additional Incidental Sick Time hours on June 1, since she is already at the maximum accrual limit.

Lucy's Incidental Sick Time use and accrual described above is depicted below:

	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE
Balance on 1st of month	96	96 + 0 = 96	96 + 0 = 96	80 + 8 = 88	88 + 8 = 96	96 + 0 = 96
Hours used during month	-0	-0	-16	-0	0	
Balance at end of month	96	96	80	88	96	
Hours to accrue on 1st of following month	+0	+0	+8	+8	+0	

Now let's say that, instead of having used no Incidental Sick Time during the month of May, Lucy used four hours in May (see below). In this case, she would end the month of May with 92 hours on record, which is four hours under the maximum allowed accrual limit of 96 hours. Therefore, Lucy would accrue four additional hours of Incidental Sick Time on June 1, bringing her back up to the 96-hour limit. Even though her regular accrual rate is eight hours per month, she is only allowed to accrue the number of hours that cause her to reach the 96-hour limit, in this case four hours.

	MAY	JUNE
Balance on 1st of month	88 + 8 = 96	92 + 4 = 96
Hours used during month	-4	
Balance at end of month	92	
Hours to accrue on 1st of following month	+4	

Part-Time Employees

Eligible part-time employees receive the proportionate equivalent to eight hours of Incidental Sick Time on the first day of employment and is based on the employee's part-time work schedule in effect upon hire.

Eligible part-time employees accrue Incidental Sick Time at a rate that is proportionate to the full-time equivalent rate of eight hours per month. The proration is based on the employee's part-time work schedule that is in effect on the first calendar day of each month. The maximum number of hours that a part-time employee can accrue in his/her Incidental Sick Time Bank is proportionate to the 96-hour equivalent for full-time employees.

At the end of each month, any unused Incidental Sick Time carries over to the following month, up to the proportionate ratio of the 96-hour maximum allowed accrual limit. If, at the end of each month, your Incidental Sick Time balance falls below your prorated maximum allowed accrual limit, you'll accrue additional Incidental Sick Time, up to the proportionate ratio of the full-time equivalent of eight hours, on the first calendar day of the following month. However, in no event will you accrue sick time so that your bank exceeds the proportionate ratio of the 96-hour maximum full-time allowance.

Example 2: Incidental Sick Time Accrual for Part-Time Employee

Susan was hired in 2002 and works 20 hours per week (50% of a full-time schedule). Because she was hired prior to 2017, she qualifies for the special one-time award of 48 hours of Incidental Sick Time (50% of 96 hours)

on January 1, 2017. As a part-time employee working a 50% schedule, her monthly accrual rate is four hours, and her maximum allowed accrual limit is 48 hours.

Susan takes eight hours of sick time in March 2017. Therefore, at the end of March, her Incidental Sick time bank has dropped to 40 hours. On April 1, 2017, Susan will start accruing Incidental Sick Time and will receive four additional hours. Susan's new Incidental Sick Time Bank on April 1 will therefore be 44 hours.

Since Susan's Incidental Sick Time balance will be below her maximum allowed limit of 48 hours on May 1, she will accrue an additional four hours on May 1. This means that, if Susan did not take any sick time in April, she will be back at the maximum allowed limit of 48 hours on May 1. Susan will not accrue any additional Incidental Sick Time in June, since she is already at the maximum allowed accrual limit at the end of May.

Moving from Part-Time to Full-Time, or Full-time to Part-Time

The monthly Incidental Sick Time accrual rate and maximum allowable accrual limit will adjust when an employee moves between part-time and full-time status.

Example 3a: Moving from 50% Part-Time Schedule to Full-Time Schedule:

Deanna is currently a part-time employee working a 50% part-time schedule. Her Incidental Sick Time accrual rate is four hours per month (50% of 8 hours), and she is allowed a maximum Incidental Sick Time Bank of 48 hours (50% of 96 hours). If she changes to a full-time schedule, starting the first day of the calendar month after her schedule change, she will begin accruing eight hours per month and have a maximum Incidental Sick Time Bank of 96 hours.

Example 3b: Moving from Full-Time to 75% Part-Time Schedule:

Deanna is currently a full-time employee who is moving to a 75% part-time schedule. As a result, her maximum allowed accrual limit will be reduced from 96 hours to 72 hours (75% of 96 hours). If, on the first of the month following her schedule change, her Incidental Sick Time balance is more than her new part-time maximum allowable limit of 72 hours, she will not accrue any additional Incidental Sick Time until she uses some sick time and falls below the maximum of 72 hours. Once Deanna's balance falls below the maximum limit, she will start accruing additional Incidental Sick Time at the rate of six hours per month (75% of 8 hours).

Regular-Status Intermittent Employees

Eligible regular-status intermittent employees will accrue Incidental Sick Time at a rate that is proportional to the full-time equivalent of eight hours per month. The proration will be based on the number of actual hours the employee worked in the previous year compared to 2,080 work hours. This monthly accrual rate will be calculated on January 1st each year and will remain in effect for the entire calendar year.

For purposes of this calculation, "Actual hours worked" includes paid Sick Time, Vacation, Workers' Compensation of less than 880 cumulative hours in a calendar year, and leaves of absence with pay (PFL and STD are excluded).

Here is an example of how sick leave is prorated for part-time intermittent employees:

Carol is hired on the first day of the year and works 20 hours per week. For her first calendar year, she works 1,040 straight-time (ST) hours. Carol's maximum allowable Incidental Sick Time accrual limit for the next calendar year will be:

1,040 ST hours worked / 2,080 work hours per year (ratio)	×	96 hours (full-time allotment)	=	48 hours

Carol will accrue four hours (50% of 8 hours) on the first calendar day of each month. The maximum accrual at any given time will be 48 hours (50% of 96 hours). Her unused Incidental Sick Time carries over to the following month, up to a maximum of 48 hours. If her Incidental Sick Time Bank falls below the 48-hour maximum, then she will accrue up to four hours of sick time on the 1st day of the next calendar month. However, in no event will she accrue sick time so that her bank exceeds 48 hours.

Incidental Sick Time Accrual during a Period of Short-Term Disability (STD), Paid Family Leave (PFL) or Workers' Compensation (WC)

Full-time employees are eligible to accrue Incidental Sick Time at the same monthly rate during the first 480 cumulative hours of absence from work in the calendar year, from the first day the employee is absent from work while on STD or PFL, which includes any absences recorded as Capped Sick Time, if applicable.

- If you are receiving Workers' Compensation (WC) benefits, you accrue Incidental Sick Time on the first 880 cumulative hours of absence from work in a calendar year, instead of the first 480 hours.
- This accrual period does not restart by moving between different leave types (for example, from STD to PFL) or by crossing over into the following calendar year.
- Once you've reached the 480 hours of absence (or 880 for WC absences), you do not start accruing Incidental Sick Time again until you return to active work.
- If you are a part-time employee, you accrue Incidental Sick Time at your same monthly part-time rate during the first 12 weeks of STD or PFL absence.

Capped Sick Time for ESC-Represented Employees

Effective January 1, 2017, ESC-represented employees, including full-time, part-time and regular-status intermittent employees with previously accrued accumulated Sick Leave, had their Sick Leave balance converted into a Capped Sick Time Bank. This Bank will consist of their accumulated Sick Leave balance as of December 31, 2016, and any Additional Sick Time (i.e., Sick Bonus) that was awarded on January 1, 2017. Employees who terminate and who are rehired on or after January 1, 2017, do not receive any type of Capped Sick Time credit for prior service. For additional details, definitions and process information, please refer to the Capped Sick Time Policy on the Intranet in the Guidance Document Library or the Time Off and Accommodations section of mypgebenefits.com.

You have the option to use available Capped Sick Time for absences because of your own illness or injury that does not qualify as an industrial injury under the terms of Workers' Compensation. You must apply for Short Term Disability (STD) benefits with the Leave and Disability Administrator for absences of more than seven calendar days that are due to your own health condition and follow the leave of absence process. (Use of Capped Sick Time for absences over seven calendar days falls under the STD policy). In these cases:

- Medical certification is required.
- You must meet the definition of "disabled" under PG&E's STD policy and follow the STD process. You must exhaust all Capped Sick Time before you are eligible to receive Wage Continuation benefits under PG&E's STD policy.
- If the waiting period applies to your leave of absence, Incidental and Capped Sick Time can be used during the STD waiting period. If no Incidental or Capped Sick Time is available, other available paid time can be used. For more details about the waiting period, please see "Waiting Period."

There may be instances when you will not need to wait until the 7th day to report a leave of absence. If you believe or you have knowledge you have a serious health condition you will need to follow the leave of absence process. For example, if you are going to have surgery and will only be out for seven calendar days, follow the leave of absence process by calling the Leave and Disability Administrator.

You may choose to use Capped Sick Time (versus Incidental Sick Time) for absences due to your own health condition of less than seven calendar days. However, unless you elect to use your Capped Sick Time in these cases, your Incidental Sick Time Bank will be used and exhausted first.

Your Capped Sick Time Bank stopped accruing additional sick time hours after the conversion on January 1, 2017.

Using Incidental and Capped Sick Time

Time is charged against your Incidental or Capped Sick Time Bank when you miss work because of an illness, a non-work-related injury, a health care appointment, when you attend to the illness of an eligible family member, or for any eligible absence if you or a family member are a victim of violence.

An employee must provide reasonable advance notice (oral or written) if the need for sick time is foreseeable (e.g., scheduled doctors' visits). If the need for sick time is unforeseeable (e.g., an unanticipated illness or a medical emergency), the employee needs to utilize their department's sick time reporting call-in policy to report the absence.

Sick time is recorded in increments of 15 minutes or more, but the sick time charged against your sick time accumulation may vary:

- For all hourly-paid employees: Personal sick time banks are charged when employees use 30 minutes or more of sick time.
- For all monthly-paid (salaried) employees: Personal sick time banks are charged when employees use four hours or more of sick time. Management employees who work for any part of the day and then take sick time will receive pay for the full day, regardless of whether the employee has sufficient sick time to cover the full day.

During continuous leave, if an employee is covered under the FMLA, CFRA, or PDL and is eligible to receive VPDI or SDI benefits, the employee may request not to use all or a portion of their sick time after the waiting period.

If you are on an STD Leave, all remaining Capped Sick Time will be used – regardless of whether the amount charged falls below the minimums noted above. Exhaustion of Capped Sick Time is mandatory to be eligible for STD Wage Continuation and LTD benefits.

Part-time employees, regular-status intermittent employees, or employees working on alternate work schedules will be charged with the same number of Incidental or Capped Sick Time hours as the hours they are scheduled to work on the day sick time is taken.

If you become sick or disabled while on vacation, you may request vacation days to be changed to sick time by submitting satisfactory medical evidence to your supervisor within 10 working days of returning to work. Qualifying reasons for requesting the change would be if you were hospitalized for one or more days or were ordered to bed rest by your doctor for two or more days. See "Illness While on Vacation" for additional information.

If you receive sick pay for time off which is later determined to have resulted from an industrial injury (for example, if you have a delayed or disputed claim), the sick time charged for your absence may be restored, up to the equivalent sum of Workers' Compensation benefits due to you.

If a holiday falls on a workday while you are receiving sick time that does not qualify under the STD policy, the day will be reported as a holiday and not as a sick time day. See "Paid Holidays" for additional information on how holidays are treated during a STD leave.

Usage and approval of Incidental or Capped Sick Time is not considered an approval of a leave unless your leave has been approved by the Leave and Disability Administrator. Contact the Leave and Disability Administrator to determine eligibility.

Using Incidental and Capped Sick Time Appropriately

The Company may request a note from your doctor or other certification of illness or injury. The Company expects all employees to use sick time only as necessary and reserves the right to take disciplinary action against any employee who abuses sick time benefits.

Transfer of Incidental and Capped Sick Time to Sick Leave or Frozen Sick

If you are an ESC-represented employee and transfer to an IBEW- or SEIU-represented position on or after January 1, 2017, you will be awarded 80 hours of Sick Leave, less any hours of Incidental Sick Time already used in the calendar year. If you have a Capped Sick Time balance, this will be converted to your Sick Leave balance. Your Incidental and Capped Sick Time balances will be zeroed out. Example: You use eight hours of Incidental Sick Time in 2017 prior to moving to an IBEW-represented position. You will be eligible for a sick balance of 72 hours when you transfer into the new position.

If you are an IBEW- or SEIU-represented employee and transfer to an ESC-represented position on or after January 1, 2017, all of your available Sick Leave will be converted to a Capped Sick Time Bank, and you will start accruing monthly Incidental Sick Time at the time of conversion, in accordance with the Incidental Sick Time policy.

If you are an ESC-represented employee and transfer to the PG&E Corporation on or after January 1, 2017, your available Incidental and Capped Sick Time will be converted to a "Frozen Sick" Bank.

If you are a PG&E Corporation employee and transfer to an ESC-represented position on or after January 1, 2017, your "Frozen Sick" Bank is converted to a Capped Sick Time Bank and you start accruing monthly Incidental Sick Time at the time of conversion.

Incidental and Capped Sick Time Upon Termination (ESC-Represented Employees)

Employees who terminate employment generally do not receive any type of monetary payout for unused Incidental or Capped Sick Time hours remaining on record at termination. In addition, employees who terminate and are rehired in 2017 or later will accrue Incidental Sick Time in the same manner as newly-hired employees. For ESC-represented employees who go on Long-Term Disability as a result of an accepted Workers' Compensation claim, Incidental Sick Time balances remain on the books until termination. (Termination is defined as resignation, retirement or death.) Then, upon termination from Long-Term Disability, these employees are paid for their unused Incidental Sick Time at the base rate of pay that was in effect on the last day worked.

Capped Sick Time Bank Conversion Upon Retirement (ESC-Represented Employees)

If you are an ESC-represented employee who retires on or after February 1, 2017, **and** you are eligible for PG&E Retiree Medical Coverage, **and** you have unused sick hours remaining in your Capped Sick Time Bank upon retirement, the value of one quarter (25%) of your remaining Capped Sick Time Bank hours will be converted into credits on a one-time basis and deposited into a Retiree Health Account upon your retirement. Employees who do not meet the eligibility requirements for PG&E Retiree Medical coverage at retirement are not eligible for this benefit.

Capped Sick Time will not be paid out upon termination or retirement under any other circumstances.

The value of the credits to be deposited into a Retiree Health Account will be determined by taking your basic rate of pay on the date of your retirement and multiplying it by one quarter (25%) of the hours remaining in your Capped Sick Time Bank. Your basic rate of pay for purposes of this calculation means the hourly equivalent of your regular base rate of pay on your date of retirement, excluding any overtime, premium pay, bonuses, incentive pay, upgrades or other pay. The calculation will include all regular sick leave hours you accrued as of Dec. 31, 2016, plus any sick bonus award for which you qualified and received on January 1, 2017. A maximum of 260 Capped Sick Time hours (25% of 1,040 hours) will be eligible for conversion to Retiree Health Account credits.

Family Sick Leave for ESC-Represented Employees

The Family Sick Leave law allows a full-time or part-time employee to use up to 50% of their maximum Incidental Sick Time accrual per year to care for themselves or an eligible family member who is physically or mentally unable to perform his/her duties due to illness, injury or a medical condition; for preventive care; for obtaining professional diagnosis or treatment of an existing health condition; or if the employee is a victim of domestic violence, sexual assault or stalking.

Eligible Family Member includes: a biological, foster, or adopted child, a stepchild, a legal ward, child of a registered domestic partner or child to whom the employee stands in loco parentis (all regardless of age and dependency status); a biological, adoptive, or foster parent, step parent, parent-in-law or legal guardian of an employee, or a person who stood in loco parentis to the employee when the employee was a minor; spouse or registered domestic partner; grandparent; grandchild; sibling, or a "designated person". A "designated person" is defined as a person identified by the employee at the time the employee requests paid sick days. The individual need not be related by blood to the employee, and their association need not be the equivalent of a family relationship.

Paid sick time must be available to be used. For example, if you are a full-time employee who accrues 96 hours of Incidental Sick Time each year, you can use up to 48 of those hours to attend to family illnesses, if the time has not already been exhausted for your own illness.

The maximum amount of Family Sick Leave to be used in any calendar year is an equivalent of 50% of what you would accrue annually. For example, if you've carried over 96 hours of sick time from the prior year and then use and accrue sick time hours throughout the year, you are eligible to use up to a maximum of 48 hours total as Family Sick Leave during the current calendar year, since your annual accrual rate is 96 hours.

All standard conditions which currently govern sick time usage by employees will apply to paid Family Sick Leave. The use of Family Sick Leave does not extend the maximum period of leave to which the employee may be entitled under the California Family Rights Act (CFRA) or the Family and Medical Leave Act (FMLA).

Sick Leave for IBEW- and SEIU-Represented Employees

The below Sick Leave program applies to IBEW- and SEIU-represented employees only.

The Sick Leave Program provides continued pay when you are temporarily unable to work because of a health care appointment, your own non-work-related illness or injury, for the preventive care or diagnosis, care or treatment of a health condition for your family member, or for specified purposes if you or a family member are a victim of domestic violence, sexual assault, or stalking. The length of time you can receive sick leave pay depends on how long you have worked for the Company and how much sick leave you have used during that time.

The use of sick leave does not extend the maximum period of leave to which an employee may be entitled under the California Family Rights Act (CFRA), the Family and Medical Leave Act (FMLA), the California Pregnancy Disability Leave (PDL) or a similar local or state leave law.

An employee must provide reasonable advance notice (oral or written) if the need for sick time is foreseeable (e.g., scheduled doctors' visits). If the need for sick time is unforeseeable (e.g., an unanticipated illness or a medical emergency), the employee needs to utilize their department's sick time reporting call-in policy to report the absence.

Earning Sick Leave

Full-Time Employees

The maximum amount of sick leave for which you are eligible depends upon your length of service with the Company. This amount is based on the number of calendar years you have continuously worked, not credited service as defined under the Company's Retirement Plan.

During Your First Ten Years of Service

Full-time employees are eligible for 80 hours (10 days) of sick leave with pay, upon attaining regular-status and completing one year of service. Thereafter, you will receive an annual allowance of current sick leave on each January 1 or on the first day you return to work each year. You must work in the calendar year to receive and use the annual allowance of current sick leave. During your first 10 years of service, you are credited annually with 80 hours (10 days) of current sick leave.

You can carry over up to eight years of sick leave credits. The maximum sick leave accumulation during your first ten years of service is 640 hours (80 hours times eight years). This is in addition to your 80 hours of current sick leave.

After Ten Years of Service

In the year in which you complete ten years of service, you can qualify for an additional 160 hours (20 days) of sick leave. These additional hours are available only if you need them. To qualify for this additional sick leave, you must have accumulated at least 320 hours (40 days) of unused sick leave during the previous eight years. Eligibility is calculated by totaling your cumulative sick leave allowance less sick leave taken — up to a maximum of 80 hours (10 days) per year — for the previous eight years.

These additional 160 hours (20 days) are not carried over from year to year; however, they will be renewed on the first day of each succeeding calendar year provided you are at work, on paid sick leave, vacation, Workers' Compensation or on a leave of absence with pay on the last working day of the year. If you are not in an eligible status on the last working day of the year, your 160 hours will be renewed on the first day of your return to work. Employees who do not qualify in their tenth year have an opportunity to qualify each year thereafter under the formula.

The maximum number of sick leave hours allowable for eligible employees who have between 10 and 20 years of service is 880 hours (including 640 hours of accumulated sick leave, 160 additional hours and 80 hours of current sick leave).

After 20 Years of Service

In the year in which you complete 20 years of service, you can qualify for 160 more hours (20 days) of sick leave credit, in addition to the current allowance of 80 hours (10 days) and the 160 additional hours (20 days) for employees with 10 or more years of service. These additional hours are only available if you need them. The same formula that is used at 10 years is used to determine if you qualify for the additional sick leave at 20 years (accumulation of unused sick leave during the previous eight years).

To qualify for this additional sick leave, you must have qualified for the additional sick leave available to employees who attain 10 years of service.

These additional 160 hours (20 days) are not carried over from year to year; however, they will be renewed on the first day of each succeeding calendar year provided you are at work, on paid sick leave, vacation, Workers' Compensation or on a leave of absence with pay on the last working day of the year. If you are not in an eligible status on the last working day of the year, your 160 hours will be renewed on the first day of your return to work. Employees who do not qualify in their twentieth year have an opportunity to qualify each year thereafter under the formula.

The maximum number of sick leave hours allowable for eligible employees with 20 or more years of service is 1,040 hours (including 640 hours of accumulated sick leave allowance, 320 additional hours and 80 hours of current sick leave).

Part-Time Employees

The maximum amount of sick leave for which you are eligible depends upon your length of service with the Company. Sick leave is based on the number of calendar years the employee has continuously worked, not credited service as defined under the Company's Retirement Plan.

During Your First Ten Years of Service

Current sick leave is awarded after one year of service and attainment of regular status and at the beginning of every calendar year thereafter.

The amount of sick leave a part-time employee receives is prorated based on the number of actual hours the employee worked in the previous year compared to 2,080 work hours. Actual hours worked include paid sick leave, vacation, Workers' Compensation of less than 880 cumulative hours in a calendar year, and leaves of absence with pay.

Employees who change from full-time to part-time status during the year keep their accumulated sick leave. On the following January 1, they are awarded their annual sick leave on a prorated basis.

You can carry over up to eight years of sick leave credits.

Here is an example of how sick leave is prorated for part-time employees:

Carol is hired on the first day of the year and works 20 hours per week. For her first calendar year, she works 1,040 straight-time (ST) hours. Carol's sick leave allotment for the next calendar year will be:

1,040 ST hours worked / 2,080 work hours per year (ratio)	×	80 hours (full-time allotment)	=	40 hours

Here is an example of how sick leave is calculated for employees who switch from full-time to part-time status:

Mark is a full-time employee who received 80 hours of sick leave effective at the beginning of the calendar year and changed to part-time status working 20 hours per week effective July 1 of that year. Mark is entitled to keep the 80 hours of sick leave he already has for the rest of the year. However, his sick leave allowance for the next calendar year will be based on the ratio of straight-time hours he worked in the prior year compared to 2,080 hours. The hours he worked in the prior year are:

1040 ST hours worked (40 hours × 26 weeks) + 520 ST hours worked (20 hours × 26 weeks) = 1,560 hours

Therefore, Mark's sick leave allowance for the next calendar year will be:

1,560 hours worked / 2,080 work hours per year (ration)	×	80 hours (full-time allotment)	=	60 hours

After Ten Years of Service

Part-time and intermittent employees qualify for a proration of the additional sick leave hours that full-time employees are eligible to receive. Eligibility for additional sick leave is determined by subtracting sick leave used (up to a maximum of the total allotment per year) from sick leave allotted during each of the eight years prior to attaining ten years of service. If the remainder is more than half of the sick leave allotted, the employee is eligible for additional sick leave hours.

Awards of additional sick leave for part-time employees are prorated based on the ratio of months of prorated service accrued in the previous eight calendar years to the full-time equivalent of 96 months. This ratio is then multiplied by 160 hours to determine the amount of additional sick leave to be awarded.

Here is an example of how additional sick leave after ten years is calculated for part-time employees:

Lucy worked 20 hours per week for eight full calendar years. Therefore, Lucy had been allotted 40 hours of sick leave per year × 8 years (sick leave credits can be carried over up to eight years), which equals 320 hours of sick pay. Lucy used a total of 120 hours of sick pay over the past eight years (and no more than 40 hours in any given year), leaving 200 of the original 320 hours. Since 200 hours is more than one-half of 320, she qualifies for the additional hours.

The number of hours to which Lucy is entitled is determined by the following formula:

Number of Months of Prorated Service = 6 months per year × 8 years = 48 months Earned for the Last Eight Years				
48 months / 96 months (ratio)	×	160 hours (full-time allotment)	=	80 additional hours (Lucy's additional sick leave)

After 20 Years of Service

Part-time and intermittent employees are eligible for additional sick leave after 20 years of service.

To qualify for this additional sick leave, you must have qualified for the additional sick leave available to employees who attain ten years of service. The same formula is used to calculate additional sick leave after 20 years as the one used to calculate additional sick leave after ten years, except that the last eight years prior to the employee's 20 years of service are used in the calculations.

Family Sick Leave (for IBEW- and SEIU-Represented Employees)

The Family Sick Leave law allows a full-time or part-time employee to use up to 50% of his/her current paid sick time allowance and 50% of the additional sick time hours after 10 (or 20) years of service per year to care for themselves or an eligible family member who is physically or mentally unable to perform his/her duties due to illness, injury or a medical condition; for preventive care; for obtaining professional diagnosis or treatment of an existing health condition. For an employee who is a victim of a qualifying act of violence, up to 12 weeks of available accrued paid sick time may be used as part of a qualifying leave. For an employee's family member who is a victim of a qualifying act of violence, up to 10 days of the available accrued paid sick leave may be used as part of a qualifying leave to aid the victim. In the event of the victim's death, up to 12 weeks of available accrued sick time may be used as part of a qualifying family member leave. The paid sick time must be available in order to be used. For example, a full-time employee who receives 80 hours of current paid sick time annually is allowed to use up to 40 hours of the 80 hours of paid sick time in the calendar year to attend to family illnesses as long as a total of 40 hours of sick time is available. A full-time employee who is eligible for the 160 (or 320) hours of additional sick time after 10 (or 20) years of service is allowed to use up to 80 (or 160) hours of the 160 (or 320) hours of additional sick time in the calendar year to attend to family illnesses as long as a total of 80 (or 160) hours of additional sick time is available.

Eligible Family Member includes: a biological, foster or adopted child, a stepchild, a legal ward, a child of a registered domestic partner or child to whom the employee stands in loco parentis (all regardless of age and dependency status); a biological, adoptive, or foster parent, step parent, parent-in-law or legal guardian of an employee, or a person who stood in loco parentis to the employee when the employee was a minor; spouse or registered domestic partner; grandparent; grandchild; sibling, or a "designated person". A "designated person" is defined as a person identified by the employee at the time of the employee request paid sick days. The individual need not be related by blood to the employee, and their association need not be the equivalent of a family relationship.

All standard conditions which currently govern sick leave usage by employees will apply to paid Family Sick Leave. The use of Family Sick Leave does not extend the maximum period of leave to which the employee may be entitled under the California Family Rights Act (CFRA) or the Family and Medical Leave Act (FMLA).

Sick Leave Bonus Vacation Award (for IBEW- and SEIU-Represented Employees)

In each of the first five calendar years of employment, full-time employees who have used 40 hours (five days) or less of paid or unpaid sick leave in the preceding year will receive one day (8 hours) of additional vacation time in the next year.

In the 10th year of service, and every five years thereafter, employees may qualify for up to 40 hours of additional vacation time based on sick leave usage. To qualify for this additional vacation, employees must have accumulated at least 200 hours (25 days) of sick leave. Eligibility is calculated by totaling the cumulative sick leave allowance less sick leave used — up to a maximum of 80 hours per year — for the previous five years.

Employees must be on active payroll and work in the year in which sick leave bonus vacation is awarded. Your sick leave bonus vacation hours will be available to you in the year in which you meet the service and sick leave usage requirements, provided you have worked one day in that year. If you terminate prior to the year in which you would have received bonus vacation days, you are not eligible for cash payment of prorated service

anniversary days. Any bonus vacation days not used in the calendar year in which they are awarded will be deferred to the next year.

Part-time and intermittent employees should refer to their particular bargaining agreements for provisions regarding eligibility for sick leave bonus vacation awards.

If you have any questions concerning your sick leave or vacation usage, contact your department's timekeeper.

Using Sick Time (for IBEW- and SEIU-Represented Employees)

Time is charged against your sick time accumulation when you miss work because of an illness, a non-work-related injury, a health care appointment, or when you attend to the illness of an eligible family member. Available sick time must be used and exhausted prior to being unpaid or requesting other types of payment. Sick leave time is recorded in increments of 15 minutes or more. Your personal sick leave accounts are charged when you use one hour or more of sick leave.

Employees working part-time or on alternate work schedules will be charged with the same number of sick time hours as the hours they are scheduled to work on the day sick time is taken.

Employees who become sick or disabled while on vacation may request vacation days to be changed to sick time by submitting satisfactory medical evidence to their supervisor within ten working days of returning to work. See "Illness While on Vacation" for additional information.

If you receive sick time pay for time off which is later determined to have resulted from an industrial injury (for example, if you have a delayed or disputed claim), the sick time charged for your absence may be restored up to an equivalent sum of Workers' Compensation benefits due.

If a holiday falls on a workday while you are receiving sick time benefits, the day will be reported as a holiday and not as a sick leave day.

Usage and approval of Sick Time is not considered an approval of a leave. Please follow the leave of absence process and contact the Leave and Disability Administrator to determine eligibility for a leave of absence.

While on approved leave designated as FMLA, CFRA, or PDL and receiving disability benefits, use of sick time is optional. Intermittent and continuous absences for the employee's own medical condition that is not eligible for FMLA, CFRA, or PDL require the use of regular sick time.

Using Sick Time Appropriately

The Company may request a note from your doctor or other certification of illness or injury. The Company expects all employees to use sick leave only as necessary and reserves the right to take disciplinary action against any employee who abuses sick leave benefits.

Terminated Employees (IBEW- and SEIU-Represented Employees)

Sick leave is not payable upon termination from employment unless you fall under one of the following categories:

- Employees who go on Long-Term Disability as a result of an accepted Workers' Compensation claim. These employees' sick leave balances remain on the books until termination. (Termination is defined as resignation, retirement or death.) Then, upon termination from Long-Term Disability, these employees are paid for their unused sick leave at the rate of pay on the last day worked.
- Employees who separate employment from the Workers' Compensation payroll because of disability. These employees will be paid for their unused sick leave at the rate of pay on the last day worked.

Employees who terminate and who are later rehired do not receive sick leave credit for prior service. Sick leave will be earned in the same manner as for new employees.

However, employees who have been laid-off and who are later re-employed within 30 months will receive sick leave credit for prior service. Employees who have been laid-off and who are later re-employed after 30 months will not receive sick leave credit unless their Company service, as defined in their Union Agreement or an

applicable letter of agreement, is determined not to be broken. Sick leave will be earned in the same manner as for new employees.

Sick Leave for Temporary Additional or Intermittent Employees Who Have Not Attained Regular Status

Eligibility, Enrollment and Cost

Eligibility

If you are a full-time or part-time temporary additional or intermittent employee who has not attained regular status and work for the Company at least 30 days, you are eligible for certain sick leave benefits after 90 cumulative days of employment, as further described in this section. For Hiring Hall employees, please refer to the Hiring Hall SPD section titled Sick Leave & Disability.

Enrollment

You are automatically covered by all of the sick leave and disability coverages described in this section, provided that you meet the eligibility requirements.

Cost of Coverage

The Company pays the full cost of the Sick Leave Program

As a temporary additional or intermittent employee who has not attained regular status, your sick leave benefits provide you with continued pay when you are temporarily unable to work because you need to attend to preventative care or care of an existing health condition, or for specified purposes if you are a victim of a qualifying act of violence. Regardless of whether you are a full-time or part-time employee, you are awarded a set number of sick leave benefits per calendar year. In most jurisdictions, you are eligible to receive 40 hours (five, eight-hour days) of sick leave with pay, immediately upon employment, which you can start using after ninety (90) cumulative days of employment. Your sick leave will not be carried over to the next calendar year. Rather, you will be awarded a new 40 hours each calendar year. You must work in the calendar year to receive and use the annual allowance of sick leave.

Eligibility and more information on sick leave covered under local city ordinances (e.g., Berkeley, Oakland and San Francisco) can be found in the Time Off and Accommodations section on mypgebenefits.com and your respective collective bargaining agreement.

The use of Sick Leave does not extend the maximum period of leave to which the employee may be entitled under the California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), or the Family and Medical Leave Act (FMLA). If you are not eligible for leave under the FMLA, CFRA, or PDL, but you are eligible for sick leave, you must use and exhaust accrued but unused sick leave first during a medical leave of absence.

Family Sick Leave

As a temporary additional or intermittent employee who has not attained regular status, you are able to use all of your awarded 24 hours (or applicable amount covered under a local city ordinance) of sick leave benefits per year for the diagnosis, care or treatment of your own existing health condition or for an existing health condition of your eligible family members. Events that qualify for Family Sick Leave include: Attending to an eligible family member who is physically or mentally unable to perform his/her duties due to illness, injury or a medical condition; obtaining professional diagnosis or treatment for the medical condition of an eligible family member; or obtaining preventative care for an eligible family member.

For Berkeley, Los Angeles, Oakland and San Francisco, an “eligible family member” is defined as a biological, foster, or adopted child, a stepchild, a legal ward, a child of a registered domestic partner or a child to whom an employee stands in loco parentis; a biological, adoptive, or foster parent, a step-parent, parent-in-law, registered domestic partner’s parent, legal guardian of any employee, or a person who stood in loco parentis when the

employee was a minor; spouse or registered domestic partner; grandparent; grandchild; sibling or a "designated person." A "designated person" is defined as a person identified by the employee at the time the employee requests paid sick days. The individual need not be related by blood to the employee, and their association need not be the equivalent of a family relationship.

West Hollywood does not define eligible family members or permit designations.

All standard conditions which currently govern sick leave usage by employees will apply to paid Family Sick Leave. The use of Family Sick Leave does not extend the maximum period of leave to which you may be entitled under the California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL) or the Family and Medical Leave Act (FMLA).

Using Sick Time (for ESC-represented Employees)

Time is charged against your sick leave award when you miss work because of an illness, a non-work related injury, or a health care appointment. Your time may be charged against your Family Sick Leave entitlement when you attend to the illness of an eligible family member. You must use Sick Time in a minimum increment of one hour when you miss work because of an illness, a non-work-related injury, a health care appointment, or to attend to the illness of an eligible family member. After the first hour, Sick Time is then recorded in increments of 15 minutes. For non-salaried employees, your personal sick leave accounts are charged when you use one hour or more of sick time. For salaried employees, your personal sick leave accounts are charged in four-hour increments. You must provide reasonable advance notice of your need for sick leave, when practical to do so, and follow your department's absence reporting and timecard protocol in order for your sick leave to be paid timely and accurately.

If you qualify for a leave of absence under the FMLA, PDL or CFRA while using your sick leave, you must also follow the leave of absence processes as described under *Time Off and Leaves* and on mypgebenefits.com.

While on approved continuous leave designated as FMLA, CFRA, or PDL, use of sick time is voluntary and the default, unless the employee informs the Leave and Disability Administrator otherwise. Intermittent and continuous absences for the employee's own medical condition that is not eligible for FMLA, CFRA, or PDL require the use of regular sick time. If you receive sick leave pay for time off which is later determined to have resulted from an industrial injury (for example, if you have a delayed or disputed claim), the sick leave charged for your absence may be restored up to an equivalent sum of Workers' Compensation benefits due.

Usage and approval of Sick Time is not considered an approval of a leave. Please follow the leave of absence process and contact the Leave and Disability Administrator to determine eligibility for a leave of absence.

Using Sick Time Appropriately

The Company may request a note from your doctor or other certification of illness or injury. The Company expects all employees to use sick leave only as necessary and reserves the right to take disciplinary action against any employee who abuses sick leave benefits. If an employee falsifies a sick leave claim, all sick leave payments related to the falsified claim must be repaid. If these offenses continue, the Company may cancel all or any part of current or cumulative sick leave credits and treat the offense as it would any other violation of a condition of employment.

Terminated Employees

In Berkeley, Oakland, Emeryville, Los Angeles and San Francisco, sick leave is not payable upon termination from employment. Employees in these jurisdictions who terminate employment with a sick leave balance and who are rehired within 12 months of termination will have their remaining sick leave balance restored upon rehire, in accordance with the California Sick Leave law. If rehired more than 12 months after termination, sick leave will be earned in the same manner as for new temporary additional or intermittent employees who have not attained regular status.

Voluntary Disability and Paid Family Leave Benefit Plan ("Voluntary Plan")

Pacific Gas and Electric Company offers the Voluntary Disability and Paid Family Leave Benefit Plan ("Voluntary Plan") to all eligible California union-represented, Management, Administrative, Technical and Security Utility employees.

California law requires that California employees participate in either the Voluntary Plan or the State Disability Insurance (SDI) and Paid Family Leave (CA PFL) Plan (collectively, "State Plan"). A Voluntary Plan must provide all the benefits of the State Plan, at least one benefit that is better, and it cannot cost employees more.

As a California Utility employee, you will be automatically enrolled in PG&E's Voluntary Plan, unless you opt out of coverage. If you opt out of the Voluntary Plan, you must participate in, and contribute to, the State Plan. Employees who elect to be covered under the State Plan can learn more by calling 1-800-480-3287 or visiting edd.ca.gov.

Voluntary Plan Disability Insurance ("VPDI") benefits are described in this section. Voluntary Plan Paid Family Leave ("VPFL") benefits are described in the Time Off and Leaves section. For additional details and definitions, visit the Voluntary Page on mypgebenefits.com for the Summary Statement of Coverage or the Voluntary Plan Document. In the event of any conflict between this Handbook and the formal Voluntary Plan document, the formal document controls.

Being approved for benefits under the Voluntary Plan does not provide job protection or return to work rights. The Voluntary Plan provides wage replacement only—it is not a type of leave of absence. For information about different types and eligibility for a leave of absence, see *Time Off and Leaves*.

The Voluntary Plan is not subject to ERISA.

Coverage

If you are initially automatically enrolled in the Voluntary Plan and later decide to withdraw from it, you must submit your request through PG&E's Benefit Service Center (in writing or electronically). If you reject coverage or withdraw from the Voluntary Plan and later wish to participate in it, you must submit your request through PG&E's Benefit Service Center (in writing or electronically).

Any California employee who opts out of the Voluntary Plan is required by California law to participate in, and contribute to, the State Plan and will need to submit claims for benefits directly to the State. Call 1-800-480-3287 or visit edd.ca.gov for more information on participating in the State Plan.

Newly Hired Employees and Newly Eligible Employees—you have the option to opt out of Voluntary Plan coverage within 31 days of becoming eligible, and the opt-out will be effective on your date of eligibility.

Making Coverage Changes in the Future

If You Opt In to the Voluntary Plan	If You Opt Out of the Voluntary Plan
Coverage change begins on the first day of the second calendar quarter after request is made.[1]	Coverage change begins on the first day of the next calendar quarter after request is made.[1]
Examples: Requests made up to March 10 are effective on July 1 Requests made up to June 10 are effective on Oct. 1 Requests made up to Sept. 10 are effective on Jan. 1 Requests made up to Dec. 10 are effective on April 1	Examples: Requests made up to March 10 are effective on April 1 Requests made up to June 10 are effective on July 1 Requests made up to Sept. 10 are effective on Oct. 1 Requests made up to Dec. 10 are effective on Jan. 1

[1] All requests need to be made by the 10th day of the third month of each quarter.

In addition, if you initially accept coverage under the Voluntary Plan, you may subsequently elect to withdraw from the Voluntary Plan during a 10-day period that precedes the effective date of an amendment or, if permitted by the Company in its sole discretion, within 10 days following the effective date of any Plan amendment.

To find out whether you are currently enrolled in the Voluntary Plan or the State Plan, you can review your current paycheck under the Employee Taxes section. The Voluntary Plan is listed as CAVPDI and the State Plan is listed as CASDI. Alternatively, you can log on to PG&E's Benefits Portal to verify your enrollment.

When Voluntary Plan Coverage Ends

Coverage generally ends upon the occurrence of the earliest of the following (see the Voluntary Plan document for more details):

- At midnight on the day that your employment ends (e.g., if your last day of employment is Wednesday, March 18, your coverage will end at midnight on Thursday, March 19);
- At midnight on the 15th full day following a temporary layoff without pay;
- At midnight on the 15th full day following a leave of absence without pay taken for educational, personal, disciplinary, political service, strike, suspension, or union business purposes;
- At midnight on the 90th full day following a leave of absence without pay taken for any other reason;
- You are no longer an eligible employee under the Voluntary Plan;
- You withdraw from coverage (effective on the first day of the next calendar quarter after the request is made in accordance with "You Opt Out of the Voluntary Plan", above);
- The Plan terminates.

Benefits and Payments

Benefit Amount

If your Voluntary Plan claim is approved, benefit payments will be made through your normal pay cycle, subject to limitations, at the applicable rate described below.

If you are a Benefit Class 1 employee (all regular, casual, probationary and regular-intermittent California employees), your weekly benefit amount is 60% of your weekly basic wage rate (subject to limitations and exclusions), with no weekly maximum imposed.

If you are a Benefit Class 2 employee (hiring hall, outage, temporary additional, probationary intermittent, and summer hire employees), your weekly benefit amount is 55% of your weekly basic wage rate (subject to limitations and exclusions), with no weekly maximum imposed.

As a requirement of the Voluntary Plan, your benefits will be no less than the weekly amount that would otherwise be paid by the State Plan.

Notwithstanding the above, benefits will be limited to the State Plan Rate (weekly amount and maximum duration) for any Disability arising during the course of employment in which the Employee receives or is eligible to receive Workers' Compensation Temporary Disability, Permanent Total Disability, Permanent Partial Disability, Life Pension, and Supplemental Benefits received as Permanent Disability Offset, under a workers' compensation or employer liability law of this State, or any other state, or the federal government. VPDI benefits will be payable for any difference between the State Plan maximum weekly benefit amount and the temporary disability or permanent disability weekly benefit amount as long as the temporary disability or permanent disability weekly benefit amount is lower than the VPDI weekly benefit amount.In no event will the weekly benefit paid, in itself and/or in combination with any other wages, exceed 100% of your weekly basic wage rate.

For monthly-paid employees, your benefit will be calculated in weekly increments using your weekly basic wage rate and paid to you on your normal monthly pay cycle. This may represent a different amount than you are accustomed to on a monthly basis because PG&E's regular pay cycle pays you the same amount every month regardless of the number of workdays you work in any given month. Voluntary Plan benefits are weekly benefits representing your weekly basic wage rate.

For each day of any full-time continuous period of disability for which benefits are payable and which is less than a full week, the amount of benefit payable will be 1/7th of the amount of the weekly benefit.

If you return to work and work part-time or intermittently and still suffer a wage loss during an eligible disability benefit period, benefits may continue to be paid on a wage loss basis. Wage loss is calculated by subtracting your current weekly wages while working part-time from your weekly basic wage rate. The difference between the two figures is your wage loss. If the wage loss is greater than your weekly VPDI benefit amount, you will receive benefits at your full VPDI rate. If the wage loss is less than your weekly VPDI amount, you will receive the amount of the wage loss only.

Weekly Basic Wage Rate

Basic Wage Rate means for the purpose of benefit determination, your regular pay excluding overtime, premium pay, bonuses, commissions, upgrades or other pay in effect, immediately prior to the commencement of a period of disability.

For the purposes of a benefit determination:

- A full-time employee's weekly basic wage rate is their monthly salary/wage, multiplied by 12 and divided by 52.
- A part-time employee's weekly basic wage rate is their part-time monthly wage, multiplied by 12 and divided by 52.
- An intermittent employee's weekly basic wage rate is a prorated amount based on the ratio of actual straight-time hours worked in the previous six-month period to the full-time hourly equivalent (1,040 hours per six-month period) rounded to the nearest month, multiplied by 12 and divided by 52.

Redirection of Benefits

You can redirect a portion of your Voluntary Plan benefits to cover certain other employee-paid benefits. If you'd like to redirect your Voluntary Plan benefits, submit your request through:

- PG&E@Work For Me > About Me > My Pay or My Benefits > Benefits Redirect. While on leave, your access to the portal will remain enabled, even with your other PG&E network access disabled.

OR

- If you do not have computer access or are otherwise unable to log in to the portal, email **Benefits@pge.com** to request a Voluntary Plan Benefits Deduction Redirect Form.

Visit Voluntary Disability and Paid Family Leave Benefit Plan on mypgebenefits.com under Time Off and Accommodations for more information and enrollment details.

Overpayments

If the calculation of benefits results in an overpayment for any reason, you are required to repay the overpayment to the Voluntary Plan to the extent permitted under applicable laws and regulations. The Company and the Leave and Disability Administrator will make reasonable arrangements with you for the repayment, including but not limited to, reduction of future Voluntary Plan benefits or the reduction of future pay, as allowed under applicable laws and regulations.

Simultaneous Coverage and Child Support Interception Deductions

For information on Simultaneous Coverage and Child Support Interception Deductions, refer to the Voluntary Plan Document on the Voluntary Plan SharePoint site: https://pge.sharepoint.com/sites/VoluntaryPlan. If you would like to request a paper copy of the Voluntary Plan document, please send an **email** to **PGELeaveteam@pge.com**.

Voluntary Plan Disability Insurance (VPDI)

VPDI benefits are payable only if you comply with all requirements for payments of benefits as set forth in, and subject to the limitations provided within, the Voluntary Plan formal plan document.

Disability benefit period means a continuous period of unemployment and disability beginning with the first day an employee files a valid VPDI claim for disability benefits. Two consecutive periods of disability due to the same or related condition and separated by not more than 60 days is considered to be one disability benefit period.

Eligibility

If you are a covered employee, you may be eligible to receive VPDI benefits if you:

- are unable to perform regular or customary work because of a physical or mental illness or injury, including but not limited to elective surgery, pregnancy, childbirth, or related medical condition.
- are unable to work because of a written order from a state or local health officer because the employee is infected with, or suspected of being infected with, a communicable disease.
- are referred or recommended by a physician to participate as a resident in an approved alcoholic recovery program or drug-free residential program (limits to benefit durations apply).

Your disability and subsequent periods of disability must be supported by a certificate from a physician or practitioner.

No benefits are payable for any disability that is not supported by the certification required by the Voluntary Plan document.

VPDI benefits are not payable under the following conditions:

- For any days that you are eligible for unemployment insurance benefits or disability insurance benefits from any state (including California).
- For any days that you are eligible for disability insurance benefits from any state (including California).
- For any days that you are receiving wages or regular wages from any employer, except that you may receive wages plus VPDI benefits to the extent the combination does not exceed your regular weekly wage, excluding overtime pay, immediately prior to the commencement of the disability. "Wages" includes sick leave, or any non-specific leave provided by the Company if it is used for purposes of disability leave. Vacation pay is not considered wages for determining eligibility for VPDI benefits.
- If you are incarcerated, including, but not limited to, in a jail, medical facility, public or private hospital, because of a criminal conviction of a federal, state or municipal law or ordinance;
- If you are confined by court order or certification as a dipsomaniac, drug addict, or sexual psychopath;
- If you commit a crime and become disabled due to an illness or injury in any way caused by the commission of, arrest, investigation, or prosecution of any crime that results in a felony conviction; or
- For any days benefits are payable under a workers' compensation or employer liability law of any state (including California) for either (i) temporary disability benefits, or (ii) permanent disability benefits for the same injury or illness. However, VPDI benefits are payable for the difference between the VPDI weekly benefit amount and the temporary disability or permanent disability weekly benefit amount, provided that benefits will be limited to the State Plan Rate (weekly amount and maximum duration).
- If you fail to be examined by a physician or practitioner chosen by the Voluntary Plan.

Waiting Period

For each Disability Benefit Period you may serve a seven-day non-payable waiting period and benefits will commence on the earliest of:

- The eighth calendar day of Disability; or
- The first day of Hospital Confinement; or
- The first day of treatment in a hospital surgical unit or a surgical clinic, provided the employee is disabled for a period of at least eight days during the Disability Benefit Period as a result of such treatment.

Maximum VPDI Benefits Amount

The maximum benefit payable for any one Disability Benefit Period will be 52 times the applicable weekly benefit amount or the amount that you would receive under the State Plan, if greater.

Termination of VPDI Benefits

Your VPDI benefits will end when:

- You do not provide any required medical certification that you continue to be disabled.
- You recover from your serious health condition or your death.
- You have received 52 weeks of VPDI benefits. You may be eligible receive a benefit for longer than 52 calendar weeks if working part-time or if you have your benefit reduced for another reason.

Independent Medical Examination

The Plan may require additional medical information to verify medical eligibility for continued VPDI benefits, including requiring an Independent Medical Examination (IME). The Plan is responsible for the cost of the exam and any related tests.

If you fail to submit to a reasonable IME or follow the IME examination process, you are subject to disqualification.

Claims Process for VPDI

You must provide advance notice of planned VPDI leave by contacting Sedgwick Claims Management Services, Inc. ("Sedgwick"), the Leave and Disability Administrator appointed by the Company to administer the claims filed under this Plan, at **1-855-732-8217** or online at **claimlookup.com/pge** and submitting the information requested. For unforeseeable events, you need to provide notification as soon as the need for leave is known.

To claim VPDI benefits under this Plan, you must file a claim with Sedgwick in a manner or fashion approved by the Leave and Disability Administrator. Claims may be submitted in writing, via telephone or electronically. Claim forms can be obtained by calling the Leave and Disability Administrator at 1-855-732-8217 or by accessing the Leave and Disability Administrator website at **claimlookup.com/pge**. Completed forms must be sent to the Leave and Disability Administrator at PG&E Service Center, P.O. Box 14495, Lexington, KY 40512-4648, faxed to 1-866-856-4862 or uploaded to the website. Except for good cause, a complete claim must be filed no later than forty-nine (49) days from the first (1st) day of Disability. Along with that claim, you must file a medical certificate and/or appropriate supporting documentation, as required per Plan terms. You must also sign and file a claim form, including a medical release authorization, in order for the claim to be accepted and considered complete.

PG&E or its authorized administrator will have the right to:

1. require supplemental forms from the treating provider or those authorized to certify your disability as often as deemed necessary;
2. have you examined by a physician/practitioner while you are claiming benefits, as often as may be reasonably required during the period payment may be due under the Voluntary Plan; and
3. request additional medical certification as often as may be reasonably required during the period payment may be due under the Voluntary Plan.

Appeals Process for VPDI

If you are denied VPDI benefits, you may appeal the denial. You may appeal within 30 days after service of the denial. An employee may also appeal if the employee does not receive notice denying benefits within 30 days after the claim was sent to the Voluntary Plan. In such cases, the employee must file the appeal after 30 days and within 60 days from the date the claim was sent to the Voluntary Plan. In both cases of denial and lack of notice of denial, the employee must send the appeal to the Employment Development Department (EDD) for processing. VPDI appeals may be sent to any EDD office.

Separately, and additionally, you may appeal the denial by sending written notice to the Company's Leave and Disability Administrator and following its administrative procedures. These internal procedures are unrelated to the appeals process established pursuant to state law. Appealing a denied claim through the Leave and Disability Administrator's internal procedures may (but need not) be pursued simultaneously; however, this will neither suspend nor extend in any way the maximum time allowed for appealing benefits to the EDD.

Payment of Benefits Pending Appeal

As provided in the California Code of Regulations, you may elect to continue to receive VPDI benefits pending the outcome of a timely appeal to an administrative law judge when the Voluntary Plan had determined you initially eligible and subsequently found you to be ineligible.

Short-Term Disability (STD) Policy for ESC-Represented Employees

Effective January 1, 2017, the PG&E Short-Term Disability (STD) Policy is available to certain Pacific Gas and Electric Company (PG&E) employees. The PG&E STD policy is comprised of two elements: Capped Sick Time and STD Wage Continuation (supplemental) benefits. PG&E STD Wage Continuation benefits supplement the Voluntary Plan Disability Insurance (VPDI) benefits or other state disability insurance programs. You may be eligible for up to 52 weeks of STD benefits. For absences for which you are also eligible and qualify under the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), California Pregnancy Disability Leave (PDL), company leave policy or any other similar or local leave law, STD runs concurrent with and does not extend the maximum period available under these laws. See "FMLA/CFRA Family Care Leave."

Below is a summary of the STD Wage Continuation policy. For additional details, definitions and process information, please refer to the Wage Continuation – Disability Policy on the Intranet in the Guidance Document Library or the Time Off and Accommodations section of mypgebenefits.com.

Eligibility

PG&E pays the full cost of Capped Sick Time and STD supplemental benefits. The STD policy applies to ESC-represented employees. Employees must be covered under the PG&E Voluntary Disability and Paid Family Leave Benefit Plan (Voluntary Plan) to be eligible for Wage Continuation benefits. Employees who opt-out of Voluntary Plan coverage will remain eligible for the CA SDI benefits. If you are an eligible employee and work outside of California, STD Wage Continuation supplements any state disability program for which you may be eligible.

If you are a not a California employee

If you are an eligible employee and work outside of California, you are required to file a claim for state disability insurance available to you in conjunction with your short-term disability leave in order to be eligible for STD Wage Continuation. State disability insurance does not typically provide job protection or return rights.

You are not eligible for coverage under the Company's STD policy if you are an IBEW- or SEIU-represented employee, a hiring hall employee, or a temporary or intermittent employee who has not attained regular status. If you are not covered by the STD policy, you may be eligible for CA SDI benefits or an unpaid leave of absence under the FMLA, CFRA, or other similar state or local leave law.

To be an eligible employee to receive benefits and be approved for leave under the PG&E STD policy, you must:

- Be unable to perform your regular or customary work for at least eight calendar days (includes non-workdays); **and**
- Be under the care and treatment of a licensed physician/practitioner or accredited religious practitioner during the first eight days of the disability. Visits with a physician for purposes of evaluation alone do not constitute medical treatment; **and**
- Have your physician/practitioner complete and return a valid medical certification form verifying your disability within the timeframe specified by the Leave and Disability Administrator; **and**
- Have lost wages because of your disability in order to receive VPDI and STD Wage Continuation benefits.

The Leave and Disability Administrator may request an independent medical examination (IME) to determine the initial disability and /or continued eligibility for STD Benefits.

Disability

"Disability" under the STD policy is defined as a physical or mental illness or injury, including any illness or injury resulting from pregnancy, childbirth, or a related medical condition, that renders an employee unable to perform his or her regular or customary work. Disability refers to an employee's own illness or injury.

You are considered unable to perform your customary work if you are ordered not to work by written order from a State or local health officer because you are infected with, or suspected of being infected with, a communicable disease or are referred or recommended by your physician to participate as a resident in an approved alcoholic or drug-free residential facility recovery home and provide certification of referral (see the Wage Continuation – Disability Policy for additional details on limitations for receiving benefits).

You may also qualify if your disability is work-related, you have met the waiting period, and:

- A decision on your Workers' Compensation (WC) claim is delayed or denied; or
- You are no longer eligible for WC temporary disability benefits due to statute limits, you have since returned to active work for more than 60 calendar days, and the absence is to cover a new period of disability.

Certificate/Certification

A complete medical certificate/certification must be filed to establish medical eligibility for your own sickness, injury, or pregnancy and must include: a diagnostic code prescribed in the International Classification of Diseases (ICD) or, where no diagnosis has yet been obtained, a detailed statement of symptoms; the date on which the disability commenced; dates and types of treatment; a return-to-work date; and a statement of medical facts, including secondary diagnoses, when applicable, within the physician's or practitioner's knowledge and scope of practice, based on your documented medical history and a physical examination by the Physician or Practitioner, indicating the Physician's or Practitioner's conclusion as to your disability, and a statement of the Physician's or Practitioner's opinion as to the expected duration of the disability.

Waiting Period

While on approved continuous leave designated as FMLA, CFRA, or PDL and receiving disability benefits, use of Capped Sick Time is optional. Incidental Sick Time and Capped Sick Time, if available, will be used as income replacement during the waiting period. Once Capped and/or Incidental Sick Time has been exhausted, vacation, floating holidays and/or in-lieu-of days may be utilized during the waiting period or the time may be unpaid at your option and subject to your supervisor's approval.

If no Capped Sick Time is available, STD Wage Continuation benefits will commence on the earliest of:

1. The eighth calendar day of Disability; or
2. The first day of Hospital Confinement; or
3. The first day of treatment in a hospital surgical unit or a surgical clinic, provided the employee is disabled for a period of at least eight days during the Disability Benefit Period as a result of such treatment.

If you have already served the seven-day waiting period for the same or a related condition within the previous 60 days, it will be considered as one Disability Benefit Period.

Claims Process

If you will be absent or expect to be absent due to your own disability (a physical or mental illness or injury, including any illness or injury resulting from pregnancy, childbirth, or a related medical condition) for more than seven calendar days, you must apply for STD by contacting the **Leave and Disability Administrator at 1-855-732-8217** or online at https://claimlookup.com/pge.

- You must provide 30 days' advance notice if the leave is foreseeable. For unforeseeable events, you need to provide notification as soon as the need for leave is known.

- You must establish medical eligibility for each period of disability by filing a claim for STD leave/benefits supported by a complete medical certification from a Medical Provider, acting within the scope of his/her practice. Once your complete documentation is received, a decision will be made to determine continued Capped Sick Time eligibility or for VPDI and STD Wage Continuation benefit payments.
- If you are eligible for FMLA, CFRA or PDL, you will not need to file a separate leave of absence with the Leave and Disability Administrator. Your eligibility for FMLA, CFRA or PDL will be reviewed based on your STD claim submittal and applicable documentation received, If you are qualified, you will be notified of your FMLA, CFRA or PDL running concurrently with your STD leave (you are required to take leave under the FMLA, CFRA and PDL at the same time you are receiving STD benefits).
- A release to return to work form is required for absences of two weeks or longer, or as the condition merits.

Capped Sick Time, when used for more than seven calendar days, is a component of the STD policy and follows the same timeframes and processes (i.e., medical certification, etc.). To remain eligible to use Capped Sick Time beyond seven calendar days, you must apply for STD. If you are later denied STD benefits, your Capped Sick Time will end on the date on which the denial decision was made. You may file an appeal of your denial with the leave and disability administrator as described starting under "Claims Process ". Capped Sick Time is not payable during the appeal period.

If you are a California employee and opt out of the Voluntary Plan, you are not eligible for STD Wage Continuation benefits under the STD policy. You will continue to follow the process as outlined in this section for using your Capped Sick Time and you will follow the leave of absence process to request a company medical and/or leaves provided under the FMLA, CFRA, PDL or local leaves, if eligible. You will also need to apply for CA SDI through the Employment Development Department (EDD).

Benefits and Payments

Capped Sick Time must be used and exhausted first (prior to being eligible for the STD Wage Continuation Benefits) and provides full income replacement.

STD Wage Continuation Benefits (WCBs) supplements the VPDI amount, so that combined, your income replacement will be up to 70% of your after-tax weekly basic wage rate prior to disability.

After approval, Capped Sick Time, VPDI and STD WCB payments will be made according to your normal pay cycle and the method of payment you've elected through PG&E's payroll department (i.e. direct deposit or printed check). VPDI benefit payments will be issued on a separate paycheck from any other pay type.

The pay cycle in which VPDI and STD WCBs will be paid is dependent upon the date on which your claim decision is made. For example: If you are a monthly-paid employee and your claim decision is made on the 25th of the month, your benefits will be paid according to your normal pay cycle the following month.

- After satisfying the waiting period and exhausting Capped Sick Time, STD Wage Continuation supplements VPDI, or other similar state benefit, to provide you with an after-tax equivalent of seventy percent (70%) of your weekly basic wage rate on the day prior to your first day of disability for up to 52 weeks.
  - The weekly 60% VPDI and 70% net STD WCBs have no maximum cap.
  - Capped Sick Time and STD WCBs are taxable; VPDI is not taxable.
  - Your STD WCB will also be coordinated with (reduced by) other benefits which you may be entitled to receive, including Social Security Disability Insurance (SSDI) and Pension benefits.
- For each day you are unable to work during any eligible period of disability which is less than a full week, the amount of daily VPDI and STD WCBs will be one-seventh (1/7) of the amount of the weekly benefit.
- If you return to work and are working part-time or intermittently and still suffering a wage loss during an eligible disability benefit period, you may be eligible for VPDI and STD WCBs.
  - Amount of STD WCBs is reduced by VPDI benefits and together with VPDI will not exceed 70% net of pre-disability weekly basic wage rate.

- There is a wage loss calculation to determine both the VPDI and STD WCBs, which means partial-day absences are generally counted as full-day absences.
- If the combination of your wages and VPDI equal or exceed 70% net of your pre-leave basic wage rate before any deductions, then no Wage Continuation benefits will be payable and this will not extend your 52 weeks of STD benefit duration.

Basic Wage Rate: For purposes of determining STD WCBs, the "Basic Wage Rate" is defined as an employee's regular pay—excluding overtime, premium pay, bonuses, commissions, upgrades or other types of pay in effect—immediately prior to the commencement of a period of Disability. **The Basic Wage Rate for an employee is calculated by multiplying the employee's monthly salary/wage rate by 12 and dividing by 52 to determine the weekly rate**. See the Voluntary Disability and Paid Family Leave Benefit Plan section for a complete definition.

For monthly-paid employees, your benefit will be calculated in weekly increments using your weekly basic wage rate and paid to you on your normal monthly pay cycle. This may represent a different amount than you are accustomed to on a monthly basis because PG&E's regular pay cycle pays you the same amount every month regardless of the number of workdays you work in any given month. STD benefits are weekly benefits representing your weekly basic wage rate and may not replace your monthly base pay.

Here is an example of how benefits are coordinated between Sick Time, STD WCBs and VPDI (Note: Your tax rate is specific to you and may differ from the example below):

Jessica has been certified and approved for eight weeks of STD benefits. The first two weeks, Jessica uses and exhausts her Capped Sick Time before being eligible for VPDI and STD WCBs for the remaining six weeks. Capped Sick Time is paid at your daily rate, which may differ from your weekly basic wage rate.

Jessica's base monthly pay is $8,000.00 and her weekly basic wage rate is $1,846.15.

$8,000.00 x 12 ($96,000.00) / 52 = $1,846.15

Under the STD policy, after Capped Sick Time ends, Jessica is eligible for a 70% after-tax (net) weekly benefit based on her pre-disability weekly basic wage rate of $1,846.15, or $1,292.31 per week, in combination with VPDI and STD WCBs. Since Jessica is eligible to receive $1,107.69 per week in VPDI benefits (60% of her weekly basic wage rate) her weekly STD benefit amount will be calculated as follows:

70% of Basic Weekly Wage Rate	60% Weekly VPDI	STD Wage Continuation per week
70% of $1,846.15 = $1,292.31	$1,107.69.	$1,292.31 – $1,107.69 = $184.62

Six (6) weeks of her STD Wage Continuation Benefit of $184.62 is $1,107.72:

$184.62 x 6 weeks = $1,107.72

Based on Jessica's tax bracket, her total taxes are equal to 30%, and she pays this 30% on her six weeks of STD Wage Continuation Benefits, which is approximately $474.74 in taxes. The $1,107.72 will be grossed up to $1,582.46 so that after taxes, Jessica will receive the estimated 70% after-tax benefit of $1,107.72, less any applicable deductions (e.g. benefit premiums, union dues, etc.).

Estimated STD Wage Continuation Payments	
6 weeks of Wage Continuation ($184.62 x 6) grossed-up =	Gross $1,582.46
30% tax =	– $474.74
$184.62 x 6 weeks =	Net $1,107.72

Below represents Jessica's total of eight weeks of STD benefits through the receipt of Capped Sick Time, STD Wage Continuation and VPDI Benefits.

Estimated STD benefits		
Capped Sick Time (2 weeks, using the weekly basic wage rate calculation and after 30% tax deduction)		$2,584.62
STD Wage Continuation (70% after tax weekly benefit (6 weeks))	$1,107.72	
VPDI payments (6 weeks at $1,107.69/week)	+ $6,646.14	
		+ $7,753.86
Total **estimated after-tax** STD benefits for 8 weeks (Capped Sick, Wage Continuation and VPDI Benefits)		$10,338.48

Maximum STD Benefit Period

You may be eligible for up to 52 weeks of STD leave for qualifying events, subject to limitations, as described within this section or in the Wage Continuation–Disability policy document.

Employees are not eligible to receive STD Wage Continuation benefits once their application for Long-Term Disability benefits is adjudicated. Two consecutive periods of disability due to the same or related condition, and separated by not more than 60 days, is considered to be one Disability Benefit Period.

You may be able to return to your former classification and work location for up to one year from the date of your first workday missed due to disability under the STD policy (Capped Sick Time and STD Wage Continuation). If your position is eliminated, then you have no greater right to reinstatement or to other benefits and conditions of employment than if you had been continuously employed (working) during the STD Benefit Period.

What Happens to Your Other Benefits

Your health care benefits will automatically continue while on STD, provided you pay the appropriate premiums, with the exception of the Health Care Flexible Spending Account (HCFSA) and the Dependent Care Flexible Spending Account (DCFSA).

For information regarding Short-Term Incentive Plan (STIP) eligibility while on a leave of absence, refer to the STIP Standard.

You are eligible to continue to accrue vacation, Incidental Sick Time and Company Paid Holidays for up to 480 hours during the STD benefit period. See “Incidental and Capped Sick Time Upon Termination (ESC-Represented Employees)” and “Vacation Program” and “Paid Holidays.”

While on STD, you will continue to accrue credited service for purposes of the Retirement Plan and eligibility for Retiree Medical coverage. If you are participating in the Retirement Savings Plan (RSP) for Union-Represented Employees, your RSP contributions will continue at your current designation. You are eligible to receive RSP employer-matching contributions on Capped Sick Time and STD Wage Continuation benefit payments.

Denial of STD Benefits and Leave

Employees are ineligible for and will be denied STD benefits if any of the following apply:

- In the case of STD Wage Continuation benefits, you are not suffering a loss of wages.
- You are claiming or receiving Unemployment Insurance (UI), PFL benefits, or Workers’ Compensation.
- You are no longer an active employee.
- You move into an ineligible Benefit Class (for example, you move into an IBEW-represented position). The effective date of the move is the date on which you become ineligible.
- You are not under the care and treatment of a physician/practitioner during some of the days on which benefits are claimed, or you do not follow the treatment recommendations of the physician/practitioner.

- Your disability is not supported by a Certificate from a physician or practitioner stating the medical facts within the Physician's or Practitioner's knowledge, a conclusion with respect to your disability, and/or an opinion with respect to the probable duration of the illness, except that a Certificate showing you have been referred or recommended by competent medical authority to participate as a resident in an alcoholism recovery program or drug free residential program need not show actual Disability.
- The claim and/or the required paperwork is not submitted within the timeframe specified by the Leave and Disability Administrator.
- The maximum STD leave limit has been reached.
- You are confined by court order or certification as a dipsomaniac, drug addict, or sexual psychopath.
- You become disabled while committing a crime, resulting in a felony conviction.
- You are confined in jail, prison, recovery home, or any other place designated by the court because of a criminal conviction.
- You fail to submit to an IME when requested to do so or follow the applicable steps in the IME process.
- You willfully make a false statement or knowingly conceal a material fact in order to obtain the payment of any benefits.

If you have Capped Sick Time, you are eligible to use it while a decision on your STD claim is pending. However, if your STD claim is denied, Capped Sick Time ends on the date the denial decision is made.

A request for STD leave may not be granted based on your history of overall unavailability and service to the Company. For example, if the granting of leave(s) has not proven effective in increasing your ability to return to work and/or remain at work, additional leave may not be granted.

STD Appeals

Employees who are denied STD benefits and leave will be provided one opportunity to appeal this decision directly through the Leave and Disability Administrator.

A period of no more than 30 calendar days will be provided to an employee to submit an appeal in writing directly to the Leave and Disability Administrator, along with any necessary and required information or documentation to support the employee's claim for benefits. The appeal decision rendered by the Leave and Disability Administrator will be final. STD (Capped Sick Time or Wage Continuation) benefits are not payable during the appeal period, even if you are receiving VPDI benefits while an appeal is pending with the Employment Development Department (EDD).

For additional information on STD Appeals, refer to the Wage Continuation – Disability Policy on the Intranet in the Guidance Document Library or the Time Off and Accommodations section of mypgebenefits.com.

Limitations and Exclusions

- Employees are not eligible to receive more than 52 weeks of STD Wage Continuation Benefits during a Disability Benefit Period.
  - If you have not reached the maximum STD Wage Continuation benefit period, but have met the waiting period and are eligible under the terms of the Long-Term Disability (LTD) Plan, you may apply for LTD benefits (available STD Wage Continuation may continue through the adjudication period for LTD benefits).
  - If you are unable to return to work due to your disabling condition once you have reached the maximum STD Wage Continuations benefits, you must apply for LTD benefits.
  - You are no longer eligible to receive benefits under the STD policy if approved to start receiving benefits under the LTD Plan.
- At no point will you be eligible for STD Wage Continuation for a work-related illness or injury (under the conditions described previously) in which the return-to-work period is less than 60 days and you have met the Elimination Period under the LTD Plan.

- Employees who are being paid PFL Wage Continuation are not eligible for STD Wage Continuation.
- Except as described elsewhere in this section for employees returning to a reduced or intermittent schedule under the STD policy, employees who receive pay from PG&E in any form will not be eligible for payments under the STD Wage Continuation policy on the same day. This includes, but is not limited to, receipt of Incidental or Capped Sick Time pay, vacation pay, floating holiday pay, Company-paid holidays, pay supplements or time off with pay.
- An employee may not delay the receipt of STD benefits for which they are eligible in order to extend their leave beyond their available FMLA, CFRA or PDL.
  - For example: If you are eligible to receive benefits under the STD policy, you cannot choose to delay receipt of these benefits by using Vacation, other pay or unpaid time off during an approved leave period.
- An employee who becomes disabled while on vacation must apply for STD benefits with the Leave and Disability Administrator within 10 calendar days in order to be eligible for STD benefits (Capped Sick Time and STD Wage Continuation). If you apply for STD benefits after the 10 calendar days, eligibility for STD benefits will be determined on a prospective basis from the date of application, and the total length of approved leave will not be extended.
- An employee who has a Date of Disability prior to January 1, 2017, or who began their Disability Benefit Period prior to January 1, 2017, will not be eligible for STD Wage Continuation benefits.

Long-Term Disability (LTD) Plan

The LTD Plan is an ERISA-subject plan that provides you with a steady source of income if you become disabled because of an accident or a long-term illness. This benefit, when combined with certain other sources of income that may be payable after the disability occurs, will be equal to 50%, 66⅔% or 70% of your basic monthly pay, depending on your employee status and when the onset of your injury/illness occurred.

As a regular full-time, part-time or intermittentemployee of Pacific Gas and Electric Company, you are automatically eligible for coverage under the Company's Long-Term Disability (LTD) Plan. (You are not eligible for LTD coverage if you are a contract or agency worker or a hiring hall employee.)

Plan Documents and Administration

The plan document for The Pacific Gas and Electric Company Long-Term Disability Program incorporates the terms of this Summary of Benefits Handbook that pertain to the plan as well as any applicable Summaries of Material Modifications.

Unless otherwise noted, if there is a conflict between the plan document and this Summary of Benefits Handbook, the plan document controls. If the plan document is silent on a specific issue, then this Summary of Benefits Handbook controls on that issue.

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

There are four different plans under which you may qualify for LTD benefits, depending on your eligibility for each Plan, when you become eligible for LTD benefits and/or when your disability begins.

Plan I

Your LTD benefits will be provided according to the provisions of Plan I if you became eligible for LTD benefits prior to January 1, 2000.

This Plan provides a monthly income equal to 50% of your basic monthly rate of pay. Benefits begin after the benefit waiting period of six cumulative months of disability.

Your LTD benefit may continue for a period of time based on your length of credited service at the time you became disabled, provided that you continue to meet the qualifying criteria. Detailed information on Plan I is available in this section.

Plan II

Your LTD benefits will be provided according to the provisions of Plan II if you became eligible for LTD benefits on or after January 1, 2000, and your onset of disability was prior to:

- June 1, 2003 (if IBEW Clerical-represented, ESC-represented or SEIU-represented), or
- October 1, 2003 (if IBEW Physical-represented).

This Plan provides a monthly income equal to 66⅔% of your basic monthly rate of pay. Benefits begin after the benefit waiting period of six cumulative months of disability.

Your LTD benefit may continue until age 65, provided that you continue to meet the qualifying criteria and your disability is not covered under the mental/nervous provisions explained later in this section under Plan II.

Plan III

Your LTD benefits will be provided according to the provisions of Plan III if you became eligible for LTD benefits on or after:

- June 1, 2003 (if IBEW Clerical- or SEIU-represented) and the onset of your disability was prior to January 1, 2018,
- June 1, 2003, (if ESC-represented), and the onset of your disability was prior to January 1, 2017, or
- October 1, 2003 (if IBEW Physical-represented) and the onset of your disability was prior to January 1, 2018.

This Plan provides a monthly income equal to 66⅔% of your basic monthly rate of pay. Benefits begin after the benefit waiting period of five consecutive months of disability.

Your LTD benefit may continue until age 65 provided that you continue to meet the qualifying criteria and you are receiving a Social Security Disability Insurance (SSDI) benefit. Detailed information on Plan III is provided in this section under Plan III.

Plan IV

Your LTD benefits will be provided according to the provisions of Plan IV for eligible employees whose onset of disability is on or after:

- January 1, 2017 (if ESC-represented), or
- January 1, 2018 (if IBEW Physical and Clerical or SEIU-represented).

This Plan provides a monthly income equal to 70% of your basic monthly rate of pay. Benefits begin after the benefit waiting period of 12 months of disability within an 18-month period.

Your LTD benefit may continue until age 65, provided that you continue to meet the qualifying criteria and you are receiving a Social Security Disability Insurance (SSDI) benefit. Detailed information on Plan IV is provided in this section under Plan IV.

How Disability Is Determined

In general, you will be considered "disabled" if an illness or injury keeps you from performing the normal duties of your job and the Company is unable to place you in a job suited to your reduced work capabilities. Inability to work with a supervisor, co-worker, department or line of business is not generally considered to be a disability.

To be considered for LTD benefits, you must be off work due to a disability for the benefit waiting period and initiate the LTD process by calling the Company's Leave and Disability Administrator at **1-855-732-8217**.

Depending on the nature of your disability (industrial or non-industrial), you must submit the necessary forms along with any required medical records to the third-party LTD administrator before you can be approved for LTD benefits. When you contact the third-party LTD administrator, they will advise you of any timing requirements for applying for benefits.

Your application and medical certification of your disability will be reviewed for approval or denial of LTD benefits. See "Claims and Appeals — Plans I, II, III and IV" for additional information.

Medical Examinations

To determine your eligibility for disability benefits under the Plan, you are required to undergo a physical examination by the Qualified Medical Provider who was or is treating you for the disabling health condition for which you are applying for LTD benefits.

To be eligible for consideration of ongoing LTD benefits under the Plan, you may be required to undergo a physical examination with your Qualified Medical Provider every six months within the first two years (24 months) of the LTD benefit period and annually thereafter.

The cost of any examination that is required for verifying your disability will be at your own expense. Contact your medical plan's member service helpline if you have questions about the cost of the office visits.

Medical examinations conducted for any purpose(s) other than establishing or verifying your disability, for example, for determining your fitness for duty, may not be used to determine your eligibility for disability benefits under the Plan.

A Qualified Medical Provider under the Plan is considered to be a licensed Doctor of Medicine ("MD") or Doctor of Osteopathic Medicine ("DO").

In order to verify your disability and/or at any time during your LTD benefit period, you may be required to undergo an Independent Medical Examination (IME) performed by a Qualified Medical Provider selected by the Company, and at the Company's expense. An IME provides additional information in the form of an independent and impartial medical opinion to verify medical eligibility for LTD benefits. Failure to participate in the IME process to verify your disability will result in a denial of future LTD benefits.

Benefit Waiting Period

You must satisfy the Benefit Waiting Period before you become eligible to receive monthly LTD benefits. The Benefit Waiting Period is the time you are not actively at work due to your disability. The Benefit Waiting Period for:

- Plan I and Plan II is the cumulative total of six months,
- Plan III is five consecutive months, and
- Plan IV is 12 months within an 18-month period.

If your disability is work-related and you qualify for LTD, LTD benefit payments will begin when you have been off work for the applicable Benefit Waiting Period. Workers' Compensation benefits offset LTD, so you may receive reduced or no LTD payments until Workers' Compensation ends. Your Benefit Waiting Period and LTD benefit entitlement period runs concurrently with your Workers' Compensation absence.

If your disability is not work-related, you must exhaust all available sick pay (including Capped Sick Time for ESC-represented employees) prior to being eligible for LTD benefit payments. If your available sick pay extends beyond the Benefit Waiting Period, LTD payments, if any, will begin once your sick pay has ended. The usage of sick pay beyond your LTD benefit eligibility date runs concurrently with and does not extend the duration of LTD benefits. You are not required to use and exhaust your Incidental Sick Time if you are an ESC-represented employee.

Benefits for Recurrent Disabilities

If you go back to work and become disabled again within 180 calendar days because of the same condition, your second disability will be counted as part of the first. This means that you will not have to satisfy a new Benefit Waiting Period for benefits to begin. The LTD plan for which you may be eligible, as well as the duration and the amount of your benefit, will be based on when you first became disabled.

Social Security Disability Insurance

Your monthly LTD benefit payment will be reduced for Social Security Disability Insurance (SSDI) benefits that you receive. In addition, SSDI benefits may be required for continued LTD benefit eligibility. Therefore, it is important that you contact the Social Security Administration as soon as possible to apply for SSDI.

- The Company has retained the services of Allsup, Inc. (Allsup) as the Company's third-party SSDI advocate. You may be referred to Allsup to represent you in applying for SSDI benefits. If Allsup agrees to represent you, Allsup will handle all of your paperwork at no cost to you. You can call Allsup at **1-888-339-0743**.
- You may elect to retain an attorney to assist you in obtaining SSDI benefits. If so, neither the Company, the third-party LTD administrator, or the third-party SSDI advocate will be responsible for any legal expenses incurred by you for pursuing SSDI benefits.
- You may be required to complete a Social Security authorization form on an annual basis to ensure your Social Security benefit award and claim status information is current.
- If you are receiving SSDI benefits, you are obligated to promptly notify the LTD administrator of any change or additional award since it will impact your LTD benefit.

Return to Work Program

Employees who have been approved for LTD must fully comply with the Company's Return to Work (RTW) Program, unless otherwise waived from participation. The provisions of the RTW Program require that within 30 days of being put on notice to participate you must:

- consult with an RTW Consultant to identify positions you are capable of performing, and
- if needed, provide your physician with the job function analysis of each position identified, and
- if needed, obtain a written assessment from your treating physician of those positions identified by you and an RTW Consultant, and return the physician's written assessment to an RTW Consultant.

Complying with the Program

Failure to comply with the RTW Program obligations within the specified time periods will result in the termination of Long-Term Disability benefits and your employment.

Within 30 days after the date on which you receive notification of the requirement to participate in the Return-to-Work Program, or within 30 days of the treating physician's assessment, you must:

- submit transfers/bids to jobs and apply for all positions that are commensurate with your reduced work capabilities, skills and qualifications and that are within your Commutable Distance. "Commutable Distance" means, as measured from your home, either (a) your last regular work location, (b) within 45 road miles or 60 minutes automotive travel time from your current residence or your residence at the time you became disabled; or (c) a distance equal to your last regular commute, if your last regular commute exceeded 45 road miles or 60 minutes automotive travel time; and
- schedule and take all qualifying tests required for the classification(s)/position(s) for which transfers and or bids have been submitted or for which you have applied. You must schedule and re-take any tests that you fail within 30 days of becoming eligible to re-test, and
- accept an offer to any position for which you are qualified.

Please refer to the applicable *Facts About Your Benefits While on LTD* booklet under the Time Off and Accommodations page on mypgebenefits.com for additional information on the LTD Plan for which you are qualified.

If You Are Placed in Another Position

If you are determined disabled for purposes of the LTD Plan, the Company will try to place you in a position in the highest available position suited to your work capabilities. The position must have a wage rate which produces a take-home pay, after taxes, which is at least equal to your LTD benefits.

If you are eligible and qualified for LTD Plan IV and you are placed in a position with a lower basic pay rate than your previous position, a work incentive benefit is offered for up to five years. This benefit will remain in effect for up to five years or your pay rate exceeds your pre-disability pay rate. Please refer to the *LTD Plan IV Facts About Your Benefits While on LTD* booklet under the Time Off and Accommodations page on mypgebenefits.com for additional information on this benefit.

What the LTD Plan Does Not Cover

LTD benefits will not be paid if your disability results from:

- A condition involving the abuse of alcohol or a controlled substance, as defined by state or federal law. However, benefits will be paid if, as a consequence of your substance use disorder, you are suffering from an illness or injury that would otherwise qualify for benefits. For example, cirrhosis of the liver which may result from alcoholism is a covered condition.
- Employment with an employer other than the Company, its domestic subsidiaries or affiliated companies, as may be designated.
- Commission of a crime which results in discharge.
- Attempted suicide.

What Happens to Your Other Benefits

Health Care Benefits

If you are enrolled in medical, dental, and/or vision when you begin LTD, you will continue to be enrolled in medical, dental, and/or vision (as applicable). Your medical plan will change to one of the LTD medical plans. You are responsible for any required premium payments as specified in the applicable health care plan and your union agreement.

Medicare

If you and/or any of your covered dependents are or become eligible for Medicare while you are on LTD, Medicare Parts A and B will become the primary payer of your medical claims and the Company's plan will be the secondary payer of medical claims. You must notify the PG&E Benefits Service Center immediately if you or a dependent is or becomes eligible for Medicare. The Company will reimburse you and any Medicare-eligible dependents under age 65 for the full standard monthly Medicare Part B premium amount. Any Medicare-eligible dependents over age 65 will be reimbursed $15.00 per month by the Company.

While on LTD, it is your responsibility to make sure you and your family members apply for Medicare coverage (both Parts A and B) in a timely manner, when eligible. ***Your LTD medical plan does not cover any amounts that would be covered by Medicare.*** In addition, the Social Security Administration may assess you a lifetime penalty for not signing up for Medicare Part B when eligible.

The Company's third-party Social Security Disability Insurance (SSDI) advocate, Allsup, can assist you with the Medicare application process. You can call Allsup at **1-888-339-0743**.

Do not sign up for Medicare Part D (prescription drugs) outside of the Pacific Gas and Electric Company's enrollment process. See *Medical Coverage for Participants on Long-Term Disability*.

Life Insurance

For as long as you qualify for LTD benefits, your Basic and Supplemental Life Insurance coverage in effect at the time you go on LTD will continue at no cost to you. Your Dependent Life Insurance coverage, if applicable, will remain in effect as long as you pay the appropriate premiums, which will be automatically deducted from your LTD pay each month. If you prefer to be billed on a monthly basis for Dependent Life Insurance coverage, please contact the PG&E Benefits Service Center at **1-866-271-8144** to request to be billed.

Accidental Death and Dismemberment (AD&D) Insurance

For as long as you qualify for LTD benefits, your Basic AD&D Insurance coverage in effect at the time you go on LTD will continue at no cost to you. Your Voluntary AD&D Insurance coverage will remain in effect as long as you pay the appropriate premiums, which will be deducted from your LTD pay each month. If you prefer to be billed on a monthly basis for Voluntary AD&D coverage, please contact the PG&E Benefits Service Center at **1-866-271-8144** to request to be billed.

Pacific Gas and Electric Company Retirement Plan and PG&E Corporation Retirement Savings Plan (RSP) for Union-Represented Employees

For IBEW- and SEIU-represented employees, and for ESC-represented employees who are approved for LTD benefits under Plans I, II or III, the period during which you are entitled to receive LTD benefits counts as "credited service" under the Retirement Plan. All employees who are approved for LTD benefits under Plan IV do not earn credited service while on LTD for purposes of the Retirement Plan; however, time on LTD does count as service toward eligibility for purposes of PG&E Retiree Medical coverage. In addition, LTD benefits paid by the Company are considered covered compensation from which you can make eligible employee contributions to the PG&E Corporation Retirement Savings Plan.

For additional information about your Retirement-related benefits while on LTD, see:

- The *Retirement Benefits*,
- The PG&E Corporation *Retirement Savings Plan* and
- *Health Care Participation*.

Other Employment and Earnings

While on LTD, you may seek other employment to supplement your LTD benefit. However, if your outside income plus your LTD benefit exceeds 100% of your pre-disability pay, including any adjustment made for other disability income you are entitled to receive, all LTD benefits will be discontinued and your employment will end.

As long as you remain on LTD, each year you must provide the third-party LTD administrator with the following verification of earnings documents:

- A copy of your federal income tax return (Form 1040); and
- If your spouse is employed and a joint return is filed, you must also provide copies of all W-2's to determine the individual earnings; or a completed income statement prepared by a certified public accountant on your earnings. The third-party LTD administrator will provide the appropriate income statement form.
- Additionally, you must provide copies of Schedules C, E, and F, as applicable, and Social Security Form 1099, if you have been awarded Social Security benefits.

You will be notified each year when to submit the verification of earnings documentation. If you do not provide the required information within 90 days of the request, a determination cannot be made on your continued eligibility for benefits, and your LTD benefit and employment will be terminated.

Plan I

LTD benefits will be provided in accordance with the provisions of Plan I for employees who became eligible for LTD prior to January 1, 2000.

Eligibility

You must have been a member of the Group Life Insurance Plan on the date you became disabled to be eligible for LTD benefits. LTD Plan I benefits are provided at no additional cost to eligible employees.

How Much the Plan Pays

LTD Plan I, combined with other benefits, provides you an income equal to 50% of your basic monthly rate of pay.

Your "basic monthly rate of pay" means your regular pay and excludes overtime, premium pay, bonuses, upgrades or other pay on the date you become disabled. The basic monthly rate of pay used to determine LTD benefits is the applicable wage rate of your regular job classification on the date you become disabled.

Benefits for employees who attained part-time or intermittent status on or after January 1, 1991, are prorated based on the ratio of actual straight-time hours worked in the previous calendar year to the full-time hourly equivalent (2,080 hours per calendar year), rounded to the nearest month.

Employees who attained part-time or intermittent status prior to January 1, 1991, are eligible for LTD Plan I benefits based on the average of their previous six months' straight-time rate of basic pay.

If You Become Eligible for LTD Benefits at Age 61 or Older

If you become eligible for LTD Plan I benefits at age 61 or older, you may receive LTD Plan I benefits for up to five years, as long as you continue to qualify for LTD Plan I benefits. However, the amount of your benefit payable subsequent to your Normal Retirement Date (as defined in the Pacific Gas and Electric Company Retirement Plan) will be recalculated as follows:

- If you had 20 years or more of credited service at the time your disability began, your monthly LTD Plan I benefit will be reduced to 40% of your basic monthly rate of pay at the time of your disability. Your LTD Plan I benefit will be further reduced by 40% of your Social Security retirement benefit and 100% of any payments received from the Pacific Gas and Electric Company Retirement Plan, if applicable.
- If you had less than 20 years of credited service at the time your disability began, your monthly LTD Plan I benefit will be reduced to 30% of your basic monthly rate of pay at the time of your disability. Your LTD Plan I benefit will be further reduced by 30% of your Social Security retirement benefit and 100% of any payments received from the Pacific Gas and Electric Company Retirement Plan, if applicable.

Coordination of Benefits

Your benefits under the LTD Plan I will be coordinated with (reduced by) other benefits which you may be entitled to receive, including but not limited to:

- The PSEBA Voluntary Wage Benefit Plan (for illnesses or injuries occurring on or before December 31, 2000) or California State Disability Insurance (CA SDI).
- The Company's Supplemental Benefits for Industrial Injury Plan and any other Workers' Compensation benefits (e.g., Temporary Disability (TD)).
- Any other disability benefits payable by an employer, including those payable under government laws financially supported by an employer.
- 50% of your primary base Social Security Disability Insurance (SSDI) benefit, including any back-pay awards.
- 100% of the monthly value of any payments received from the Pacific Gas and Electric Company Retirement Plan for your credited service under the Retirement Plan, including the actuarially-equivalent monthly value of any lump-sum Cash Balance benefit paid pursuant to Part III of the Retirement Plan.
- Life pensions paid under the Workers' Compensation Act for injuries occurring on or after July 1, 1977 (you are entitled to a life pension if you have received a disability rating of 70% or greater).
- 30% or 40% of your Social Security retirement benefit (depending on your credited service at the time your disability began).

For purposes of calculating your LTD Plan I benefit, it is assumed that you qualify for Social Security disability benefits unless your claim is rejected twice by the Social Security Administration. (You must apply for Social Security disability benefits a second time if your claim is denied the first time.)

Here is an example of how the coordination of benefits provision works for Plan I:

Sandra has become disabled and has a basic monthly rate of pay of $5,000. The LTD Plan I provides Sandra with a monthly income of $2,500 (50% of $5,000) from all sources. If she is eligible for Social Security disability benefits of $900 a month and $1,000 a month from CA SDI, her benefit from LTD Plan I will be:

- LTD monthly income $2,500
- Less CA SDI payments for the month (maximum benefit — 52 weeks) -$1,000
- Less 50% of monthly primary Social Security benefit - $450
- Sandra's monthly benefit from the LTD Plan $1,050

When the CA SDI payments stop after 52 weeks, Sandra's benefit from the LTD Plan I will increase to $2,050 ($2,500 minus $450 Social Security offset). This LTD Plan I benefit of $2,050, combined with her Social Security benefit of $900, provides her with a total monthly income of $2,950.

While on LTD, adjustments to your monthly LTD benefit will be made any time coordinating benefits cease, begin, or change, regardless of any previous awards or denials you have received. Therefore, you must promptly provide the third-party LTD administrator with a copy of any disability benefit denials, award notifications or changes that you receive from Social Security, the State of California or other disability benefit sources, as it will affect your LTD benefit payments. These adjustments are made on a retroactive basis. For example, if you were denied Social Security disability benefits and later received a retroactive award for these benefits, your LTD benefit would be adjusted retroactively. You must promptly reimburse the Company for any overpayment of LTD benefits that results from your receipt of any state disability benefits, Social Security disability benefits or other coordinating benefit payments. If you had an initial offset for coordinating benefits that are later denied, the Company will reimburse you for adjustments made that result in an underpayment in LTD benefits.

You are obligated to promptly refund to the Company any overpayment made to you as determined by the third-party LTD administrator for any reason, including, but not limited to, any changes made to any estimated or actual offsets used in determining the LTD Plan I benefit. Failure to comply within the specified time limits will result in your overpayment balance being deducted from your monthly LTD benefit payment until your overpayment is fully recovered.

Maximum LTD Benefit Period

The maximum duration of your LTD Plan I benefit depends on the length of your credited service as defined under the Pacific Gas and Electric Company Retirement Plan.

Your Length of Credited Service —As of the date of disability	LTD Benefits are Payable Up To
Less than 5 years	5 years
At least 5 years but less than 15 years	A period of time equal to your length of credited service (unless you reach normal retirement age under the Pacific Gas and Electric Company Retirement Plan)
15 years or more	Normal retirement age as defined under the Pacific Gas and Electric Company Retirement Plan

Employees who become eligible for LTD Plan I benefits at age 61 or older should refer to "If You Become Eligible for LTD Benefits at Age 61 or Older" for information regarding their maximum LTD Plan I benefit period.

When LTD Benefits End

LTD Plan I benefits will end on the earliest of the following events:

- You recover from your disability and are medically released to return to work.

- You refuse a qualifying position at the Company which has duties equal to your reduced work capabilities.
- You start earning income from some other form of work that is equal to more than 50% of your basic monthly rate of pay on the last day you worked prior to becoming disabled.
- You do not comply with the provisions of the verification of earnings requirement.
- You reach normal retirement age under the Pacific Gas and Electric Company Retirement Plan (unless LTD eligibility begins at age 61 or older; see "If You Become Eligible for LTD Benefits at Age 61 or Older."
- You are no longer eligible for LTD Plan I benefits because you reach the maximum benefit period (see "Maximum LTD Benefit Period."
- You do not follow your physician's recommended treatment program.
- You do not comply with the provisions of the medical certification requirement.
- You do not comply with the provisions of the Company's Return to Work Program.
- You are terminated or leave the Company.
- You return to work at the Company as a hiring hall employee.
- Your death.

Plan II

LTD benefits will be provided in accordance with the provisions of Plan II for employees who became eligible for LTD on or after January 1, 2000, and whose onset of disability was prior to :

- June 1, 2003 (if IBEW Clerical-, ESC- or SEIU-represented), or
- October 1, 2003 (if IBEW Physical-represented).

Eligibility

You must have been a member of the Group Life Insurance Plan on the date you became disabled to be eligible for LTD benefits. LTD Plan II benefits are provided at no additional cost to eligible employees.

How Much the Plan Pays

LTD Plan II, combined with other benefits, provides you an income equal to 66⅔% of your basic monthly rate of pay.

Your "basic monthly rate of pay" means your regular pay on the date you become disabled and excludes overtime, premium pay, bonuses, upgrades or other pay. The basic monthly rate of pay used to determine LTD benefits is the applicable wage rate of your regular job classification on the date you become disabled.

Benefits for employees who attained part-time or intermittent status on or after January 1, 1991, are prorated based on the ratio of actual straight-time hours worked in the previous calendar year to the full-time hourly equivalent (2,080 hours per calendar year), rounded to the nearest month.

Employees who attained part-time or intermittent status prior to January 1, 1991, are eligible for LTD Plan II benefits based on the average of their previous six months' straight-time rate of basic pay.

If You Become Eligible for LTD Benefits at Age 61 or Older

If you become eligible for LTD Plan II benefits at age 61 or older, you may receive LTD Plan II benefits for up to five years, as long as you continue to qualify for LTD Plan II benefits. However, the amount of your benefit payable subsequent to your Normal Retirement Date (as defined in the Pacific Gas and Electric Company Retirement Plan) will be reduced by 100% of your Social Security retirement benefit and 100% of any payments received from the Pacific Gas and Electric Company Retirement Plan, if applicable.

Coordination of Benefits

Your benefits under the LTD Plan II will be coordinated with (reduced by) other benefits which you may be entitled to receive, including but not limited to:

- The PSEBA Voluntary Wage Benefit Plan (for illnesses or injuries occurring on or before December 31, 2000) or California State Disability Insurance (CA SDI).
- The Company's Supplemental Benefits for Industrial Injury Plan and any other Workers' Compensation benefits (e.g., Temporary Disability (TD)).
- Any other disability benefits payable by an employer, including those payable under government laws financially supported by an employer.
- 100% of your primary base Social Security Disability Insurance (SSDI) benefit, including any back-pay awards.
- 100% of the monthly value of any payments received from the Pacific Gas and Electric Company Retirement Plan for your credited service under the Retirement Plan, including the actuarially-equivalent monthly value of any lump-sum Cash Balance benefit paid pursuant to Part III of the Retirement Plan.
- Life pensions paid under the Workers' Compensation Act for injuries occurring on or after July 1, 1977 (you are entitled to a life pension if you have received a disability rating of 70% or greater).
- 100% of your Social Security retirement benefit.

For purposes of calculating your LTD Plan II benefit, it is assumed that you qualify for Social Security disability benefits unless your claim is rejected twice by the Social Security Administration. (You must apply for Social Security disability benefits a second time if your claim is denied the first time.)

Here is an example of how the coordination of benefits provision works for Plan II:

Sandra has become disabled and has a basic monthly payof $7,500. The LTD Plan II provides Sandra with a monthly income of $5,000 — 66⅔% of $7,500 — from all sources. If she is eligible for Social Security disability benefits of $1,000 a month and $3,600 a month from CA SDI, her LTD benefit from the LTD Plan II will be:

▪ LTD monthly income	$5,000
▪ Less CA SDI payments for the month (maximum benefit — 52 weeks)	-$3,600
▪ Less 100% of monthly primary Social Security benefit	- $1,000
▪ Sandra's monthly benefit from the LTD Plan	$400

When the CA SDI payments stop after 52 weeks, Sandra's benefit from the Company's LTD Plan II will increase to $4,000 ($5,000 minus $1,000 for Social Security offset). This LTD benefit of $4,000, combined with her Social Security benefit of $1,000, provides her with a total monthly income of $5,000.

While on LTD, adjustments to your monthly LTD benefit will be made any time coordinating benefits cease, begin, or change, regardless of any previous awards or denials you have received. Therefore, you must promptly provide the third-party LTD administrator with a copy of any disability benefit denials, award notifications or changes that you receive from Social Security, the State of California or other disability benefit sources, as it will affect your LTD benefit payments. These adjustments are made on a retroactive basis. For example, if you were denied Social Security disability benefits and later received a retroactive award for these benefits, your LTD benefit would be adjusted retroactively. You must promptly reimburse the Company for any overpayment of LTD benefits that results from your receipt of any state disability benefits, Social Security disability benefits or other coordinating benefit payments. If you had an initial offset for coordinating benefits that are later denied, the Company will reimburse you for adjustments made that result in an underpayment in LTD benefits.

You are obligated to promptly refund to the Company any overpayment made to you as determined by the third-party LTD administrator for any reason, including, but not limited to, any changes made to any estimated or actual offsets used in determining the LTD Plan II benefit.

Maximum LTD Benefit Period

The maximum duration of your LTD Plan II benefit will be to age 65, unless your disability is a mental/nervous disability and is subject to a two-year limit. You may not continue to receive LTD Plan II benefits beyond age 65 unless you became eligible for LTD Plan II benefits at age 61 or older. In such a case, you would be entitled to a maximum LTD Plan II benefit period of five years.

Two-Year Limit on Mental/Nervous Disabilities

In general, LTD Plan II benefits for mental/nervous disabilities are subject to a two-year maximum benefit period. The two-year limit will not apply if your disability is due to a severe mental disorder including schizophrenia, dementia, organic brain syndromes, delirium, amnesia syndromes or organic delusional or hallucinogenic syndromes. If you are awarded Social Security disability benefits prior to the end of the two-year limit, your LTD Plan II benefit may continue up to your Normal Retirement Date as long as you continue to qualify for LTD Plan II benefits. If you are hospitalized or institutionalized on the date your two-year limit expires, your LTD Plan II benefit will continue for the duration of the stay, but not to exceed your Normal Retirement Date.

When LTD Benefits End

LTD Plan II benefits will end on the earliest of the following events:

- You recover from your disability and are medically released to return to work.
- You refuse a position at the Company which has duties equal to your reduced work capabilities.
- You start earning income from some other form of work that is equal to more than 33⅓% of your basic monthly rate of pay on the last day you worked prior to becoming disabled.
- You do not comply with the provisions of the verification of earnings requirement.
- You reach normal retirement age under the Pacific Gas and Electric Company Retirement Plan (unless LTD eligibility begins at age 61 or older; see "If You Become Eligible for LTD Benefits at Age 61 or Older."
- You reach the two-year limit to which some mental/nervous disabilities are subject.
- You do not follow your physician's recommended treatment program.
- You do not comply with the provisions of the medical certification requirement.
- You do not comply with the provisions of the Company's Return to Work Program.
- You are terminated or leave the Company.
- You return to work at the Company as a hiring hall employee.
- Your death.

Plan III

LTD benefits will be provided in accordance with the provisions of Plan III for employees who became eligible for LTD on or after:

- June 1, 2003 (if IBEW Clerical- or SEIU-represented) and whose onset of disability was prior to January 1, 2018,
- June 1, 2003, (if ESC-represented), and whose onset of disability was prior to January 1, 2017, or
- October 1, 2003 (if IBEW Physical-represented) and whose onset of disability was prior to January 1, 2018.

Eligibility

LTD Plan III benefits are provided at no additional cost to eligible employees.

How Much the Plan Pays

LTD Plan III, combined with other benefits, provides you an income equal to 66⅔% of your basic monthly rate of pay.

Your "basic monthly rate of pay" means your regular pay excluding overtime, premium pay, bonuses, upgrades or other pay, on the date you become disabled. In addition, it excludes any work incentive benefit amount you may have previously been eligible to receive. The basic monthly rate of pay used to determine LTD benefits is the applicable wage rate of your regular job classification on the date you become disabled.

Benefits for employees who attained part-time or intermittent status on or after January 1, 1991, are prorated based on the ratio of actual straight-time hours worked in the previous calendar year to the full-time hourly equivalent (2,080 hours per calendar year), rounded to the nearest month.

Employees who attained part-time or intermittent status prior to January 1, 1991, are eligible for LTD Plan III benefits based on the average of their previous six months' straight-time rate of basic pay.

Coordination of Benefits

Your benefits under the LTD Plan III will be coordinated with (reduced by) other benefits which you may be entitled to receive, including but not limited to:

- Benefits payable under a state disability plan (for example, CA SDI) or the Company's Voluntary Plan, the Company's Supplemental Benefits for Industrial Injury Plan and any other Workers' Compensation benefits (e.g., Temporary Disability (TD)).
- Any other disability benefits payable by an employer, including those payable under government laws financially supported by an employer.
- 100% of your primary and family base Social Security disability benefit, including any back-pay awards.
- 100% of the monthly value of any payments received from the Pacific Gas and Electric Company Retirement Plan for your credited service under the Retirement Plan; including the actuarially-equivalent monthly value of any lump-sum Cash Balance benefit paid pursuant to Part III of the Retirement Plan.
- Life pensions paid under the Workers' Compensation Act for injuries occurring on or after July 1, 1977 (you are entitled to a life pension if you have received a disability rating of 70% or greater).
- 100% of your Social Security retirement benefit.
- Any amount payable under the Railroad Retirement Act.

For purposes of calculating your LTD Plan III benefit, no Social Security offset will be assumed until Social Security disability benefits are actually awarded. You are responsible for immediately notifying the third-party LTD administrator of such an award, and for repaying the Company the full amount of the LTD overpayment at the time you receive your Social Security award.

Here is an example of how the coordination of benefits provision works for Plan III:

Sandra has become disabled and has a basic monthly rate of pay of $8,400. The LTD Plan III provides Sandra with a monthly income of $5,600 — 66⅔% of $8,400 — from all sources. If she has been awarded primary and family Social Security disability benefits of $1,800 a month ($1,200 primary plus $600 family), and she is receiving $3,600 a month from CA SDI, her LTD benefit from the LTD Plan III will be:

LTD monthly income	$5,600
Less CA SDI payments for the month (maximum benefit — 52 weeks)	- $3,600
Less 100% of monthly primary and family's Social Security benefits	- $1,800
Sandra's monthly benefit from the LTD Plan	$200

When the CA SDI payments stop after 52 weeks, Sandra's benefit from the Company's LTD Plan III will increase to $3,800 ($5,600 minus $1,800 for primary and family Social Security offset). This LTD benefit of $3,800, combined with her Social Security benefit of $1,800, provides her with a total monthly income of $5,600.

While on LTD, adjustments to your monthly LTD benefit will be made any time coordinating benefits cease, begin or change, regardless of any previous awards or denials you have received. Therefore, you must promptly provide the third-party LTD administrator with a copy of any disability benefit denials, award notifications or changes that you receive from Social Security, the State of California or other disability benefit sources, as it will affect your LTD benefit payments. These adjustments are made on a retroactive basis. For example, if you were denied Social Security disability benefits and later received a retroactive award for these benefits, your LTD benefit would be adjusted retroactively. You must promptly reimburse the Company for any overpayment of LTD benefits that results from your receipt of any state disability benefits, Social Security disability benefits or other coordinating benefit payments. If you had an initial offset for coordinating benefits that are later denied, the Company will reimburse you for adjustments made that result in an underpayment in LTD benefits.

You are obligated to promptly refund to the Company any overpayment made to you as determined by the third-party LTD administrator for any reason, including, but not limited to, any changes made to any estimated or actual offsets used in determining the LTD Plan III benefit. If an overpayment in LTD Plan III benefits occurs due to a Social Security disability benefit award, you have 30 days to repay the overpaid amount. If you do not repay the Company within 30 days of receiving the SSDI benefit payment, your LTD benefit will stop until the full overpayment is recouped. If you resign or retire prior to repaying the full overpayment, the Company will seek restitution through the legal process.

Annual Social Security Authorization Form

You will be required to complete a Social Security authorization form on an annual basis to ensure your Social Security benefit award and claim status information is current.

Maximum LTD Benefit Period

Under Plan III, the maximum duration of your LTD Plan III benefit is as follows:

- If you are not receiving a Social Security disability benefit at the end of two years of LTD eligibility, your LTD Plan III benefit will stop and your employment will be terminated at that time.
- If you are receiving a Social Security disability benefit at the end of two years of LTD eligibility, the maximum duration of your LTD Plan III benefit will be to the earlier of age 65, or the termination of Social Security disability benefits.
- Notwithstanding the foregoing, if you are age 63 or older when you become eligible for an LTD Plan III benefit, the maximum duration of your LTD Plan III benefit will be two years.

Extension of LTD Plan III Benefits Beyond Two Years

If the Company's third-party Social Security Disability Insurance (SSDI) advocate is representing your interest in applying for Social Security disability benefits and if you have not received a final Social Security disability ruling within 24 months of the initial receipt of LTD benefits through no fault of your own, as determined by the advocate, you may receive a monthly extension of up to an additional 36 months of LTD benefits or until you reach age 65, whichever happens first. You must fully cooperate with the advocate and must defer the processing of your Social Security application to the discretion of the advocate. If the advocate has closed your claim for Social Security representation for any reason during the extension period, your LTD benefits and employment will be terminated. In addition, if Social Security disability benefits have not been awarded at the end of the extension, your LTD benefits and employment will be terminated.

If you have been terminated from LTD and employment with Pacific Gas and Electric Company, and are later awarded Social Security disability benefits retroactive to the period in which you were receiving LTD benefits, your LTD benefits and employment will be reinstated retroactive to the original date that LTD benefits ended.

When LTD Benefits End

LTD Plan III benefits will end on the earliest of the following events:

- You recover from your disability and are medically released to return to work.
- You refuse a qualifying position at the Company which has duties equal to your reduced work capabilities.
- You start earning income from some other form of work that is equal to more than 33⅓% of your basic monthly rate of pay on the last day you worked prior to becoming disabled.
- You do not comply with the provisions of the verification of earnings requirement.
- You do not comply with providing the annual Social Security authorization form.
- You reach age 65 (normal retirement age) under the Pacific Gas and Electric Company Retirement Plan.
- You reach the two-year limit and have not been awarded a Social Security disability benefit.
- You reach the two-year limit because you were age 63 or older when you became eligible for LTD Plan III benefits.
- Your claim for Social Security representation is closed by the advocate for any reason during the monthly extension period.
- You have not been awarded Social Security disability benefits at the end of the monthly extension.
- You do not follow your physician's recommended treatment program.
- You do not comply with the provisions of the medical certification requirement.
- You do not comply with the provisions of the Company's Return to Work Program.
- You are terminated or leave the Company.
- You return to work at the Company as a hiring hall employee.
- Your death.

Plan IV

LTD benefits will be provided according to the provisions of Plan IV for eligible employees whose onset of disability was on or after:

- January 1, 2017 (if ESC-represented), or
- January 1, 2018 (if IBEW- or SEIU-represented).

Eligibility

LTD Plan IV benefits are provided at no additional cost to eligible employees. In order for PG&E to consider your eligibility, the claim must be filed prior to termination and during the period of time in which the employee is otherwise eligible for benefits under the plan.

How Much the Plan Pays

LTD Plan IV, combined with other benefits, provides you an income equal to 70% of your basic monthly rate of pay.

Your "basic monthly rate of pay" means your regular pay excluding overtime, premium pay, bonuses, upgrades or other pay, on the date you become disabled. In addition, it excludes any work incentive benefit amount you may have previously been eligible to receive. The basic monthly rate of pay used to determine LTD benefits is the applicable wage rate of your regular job classification on the date you become disabled.

Benefits for employees who attained part-time or intermittent status on or after January 1, 1991, are prorated based on the ratio of actual straight-time hours worked in the previous calendar year to the full-time hourly equivalent (2,080 hours per calendar year), rounded to the nearest month.

Employees who attained part-time or intermittent status prior to January 1, 1991, are eligible for LTD Plan IV benefits based on the average of their previous six-months' straight-time rate of basic pay.

Coordination of Benefits

Your benefits under the LTD Plan IV will be coordinated with (reduced by) other benefits which you may be entitled to receive, including but not limited to:

- California State Disability Insurance (CA SDI).
- Voluntary Plan Disability Insurance (VPDI).
- The Company's Supplemental Benefits for Industrial Injury Plan and any other Workers' Compensation benefits (e.g., Temporary Disability (TD)).
- Any other disability benefits payable by an employer, including those payable under government laws financially supported by an employer.
- 100% of your primary Social Security Disability Insurance (SSDI) benefit, including any back-pay awards.
- 100% of the monthly value of any payments received from the Pacific Gas and Electric Company Retirement Plan for your credited service under the Retirement Plan; including the actuarially-equivalent monthly value of any lump-sum Cash Balance benefit paid pursuant to Part III of the Retirement Plan.
- Life pensions paid under the Workers' Compensation Act for injuries occurring on or after July 1, 1977 (you are entitled to a life pension if you have received a disability rating of 70% or greater).
- 100% of your Social Security retirement benefit.
- Any amount payable under the Railroad Retirement Act.

For purposes of calculating your LTD Plan IV benefit, no Social Security offset will be assumed until benefits are actually awarded. You are responsible for immediately notifying the third-party LTD administrator of such an award, and for repaying the Company the full amount of the LTD overpayment at the time you receive your award.

Here is an example of how the coordination of benefits provision works for work-related conditions. For conditions resulting from employment at PG&E, employees do not have to exhaust sick time prior to going on LTD—any unused sick time is paid out once LTD ends:

Sandra has become disabled and has a basic monthly pay of $8,400. Because Sandra's absence is work-related, the table below illustrates what her eligible LTD or VPDI benefits will be after her Workers' Compensation (WC) benefits end. Sandra's time on WC runs concurrently with her 52-week LTD Benefit Waiting Period and LTD benefit entitlement period.

The LTD Plan IV assures Sandra of a monthly income of $5,880 — 70% of $8,400 — from all sources. If she has been awarded primary Social Security Disability benefits of $1,800 a month and receives $4,000 a month from VPDI, her LTD benefit from the LTD Plan IV will be:

LTD monthly income	$5,880
Less VPDI payments for the month (maximum benefit — 52 weeks)	$4,000 (VPDI)
Less 100% of monthly primary Social Security Disability benefit	- $1,800
Sandra's monthly benefit from the LTD Plan	$80 (VPDI offset)

Here is an example of how the coordination of benefits provision works for non-work-related conditions:

Sandra has become disabled and has a basic monthly pay of $8,400. Sandra has a balance of eight weeks of Capped Sick Time when her absence begins. Because Sandra's absence is not work-related, she is required to use and exhaust her full eight weeks of Capped Sick Time prior to being eligible to receive CA SDI or VPDI benefits. This means she will not begin to receive the 52 weeks of CA SDI or VPDI benefits until two months after her first day of absence. However, her 52-week LTD Benefit Waiting Period began on her first day of absence due to her disability.

The LTD Plan IV assures Sandra of a monthly income of $5,880 — 70% of $8,400 — from all sources. If she has been awarded primary Social Security Disability benefits of $1,800 a month and $4,000 a month from CA SDI or VPDI, her LTD benefit from the LTD Plan IV will be:

First two months:

▪ LTD monthly income	$5,880
▪ Less VPDI payments (maximum benefit — 8 weeks remaining after CA SDI or VPDI waiting period and use of Capped Sick Time)	- $4,000 (VPDI)
▪ Less 100% of monthly primary Social Security Disability benefit	- $1,800
▪ Sandra's monthly benefit from the LTD Plan	$80 (VPDI offset)

Beginning in third month:

▪ LTD monthly income	$5,880
▪ Less 100% of monthly primary SSDI benefit	- $1,800
▪ Sandra's monthly benefit from the LTD Plan	$4,080

When the CA SDI or VPDI payments stop due to having reached the maximum CA SDI or VPDI benefits payable, Sandra's benefit from the Company's LTD Plan IV will increase to $4,080 ($5,880 minus $1,800 for primary Social Security offset). This LTD benefit of $4,080, combined with her Social Security benefit of $1,800, provides her with a total monthly income of $5,880.

While on LTD, adjustments to your monthly LTD benefit will be made any time coordinating benefits cease, begin or change, regardless of any previous awards or denials you have received. Therefore, you must promptly provide the third-party LTD administrator with a copy of any disability benefit denials, award notifications or changes that you receive from Social Security, the State of California, Voluntary Plan or other disability benefit sources, as it will affect your LTD benefit payments. These adjustments are made on a retroactive basis. For example, if you were denied Social Security Disability benefits and later received a retroactive award for these benefits, your LTD benefit would be adjusted retroactively. You must promptly reimburse the Company for any overpayment of LTD benefits that results from your receipt of any state disability benefits, Voluntary Plan Disability benefits, Social Security disability benefits or other coordinating benefit payments. If you had an initial offset for coordinating benefits that are later denied, the Company will reimburse you for adjustments made that result in an underpayment in LTD benefits.

You are obligated to promptly refund to the Company any overpayment made to you as determined by the third-party LTD administrator for any reason, including, but not limited to, any changes made to any estimated or actual offsets used in determining the LTD Plan IV benefit. If an overpayment in LTD Plan IV benefits occurs, you have 30 days to repay the overpaid amount. If you do not repay the Company or agree to a reasonable repayment plan within 30 days of receiving the benefit or being notified of the overpayment, your LTD benefit will stop until the full overpayment is recouped. If the Participant returns to work, resigns or retires from the Company prior to repaying the full LTD overpayment, the Company will seek restitution through the legal process (including garnishment of wages, to the extent permitted under applicable law).

Annual Social Security Authorization Form

You will be required to complete a Social Security authorization form on an annual basis to ensure your Social Security benefit award and claim status information is current.

Maximum LTD Benefit Period

Under Plan IV, the maximum duration of your LTD Plan IV benefit is as follows:

- If you are not receiving a Social Security Disability benefit at the end of two years of LTD eligibility, your LTD Plan IV benefit will stop and your employment will be terminated at that time.
- If you are receiving a Social Security Disability benefit at the end of two years of LTD eligibility, the maximum duration of your LTD Plan IV benefit will be to the earlier of age 65, or the termination of Social Security Disability benefits.
- Notwithstanding the foregoing, if you are age 63 or older when you become eligible for an LTD Plan IV benefit, the maximum duration of your LTD Plan IV benefit will be two years.

Extension of LTD Plan IV Benefits Beyond Two Years

If the Company's third-party Social Security Disability advocate is representing your interest in applying for Social Security Disability benefits and if you have not received a final Social Security Disability ruling within 24 months of the initial receipt of LTD benefits through no fault of your own, as determined by the advocate, you may receive a monthly extension of up to an additional 36 months of LTD benefits or until you reach age 65, whichever happens first. You must fully cooperate with the advocate and must defer the processing of your Social Security application to the discretion of the advocate. If the advocate has closed your claim for Social Security representation for any reason during the extension period, your LTD benefits and employment will be terminated. In addition, if Social Security Disability benefits have not been awarded at the end of the extension, your LTD benefits and employment will be terminated.

If you have been terminated from LTD and employment with Pacific Gas and Electric Company, and are later awarded Social Security Disability benefits retroactive to the period in which you were receiving LTD benefits, your LTD benefits and employment will be reinstated retroactive to the original date that LTD benefits ended. Reinstatement of said benefits and employment will only occur if you continued to meet, without lapse, all applicable and appropriate eligibility provisions of LTD Plan IV during the period in which you were terminated.

When LTD Benefits End

Provided that you follow the treatment recommended by your physician, LTD Plan IV benefits will end on the earliest of the following events:

- You recover from your disability and are medically released to return to work.
- You refuse a qualified position at the Company which has duties equal to your reduced work capabilities, and that pays equal to or more than your LTD rate of pay.
- You start earning income from some other form of work that is equal to more than 30% of your basic monthly rate of pay on the last day you worked prior to becoming disabled.
- You do not comply with the provisions of the verification of earnings requirement.
- You do not comply with providing the annual Social Security authorization form.
- You reach age 65 (normal retirement age) under the Pacific Gas and Electric Company Retirement Plan.
- You reach the two-year limit and do not have a Social Security Disability benefit.
- You reach the two-year limit because you were age 63 or older when you became eligible for LTD Plan IV benefits.
- Your claim for Social Security Disability representation is closed by the advocate for any reason during the monthly extension period.
- You have not been awarded Social Security Disability benefits at the end of the monthly extension.
- You do not follow your physician's recommended treatment program.
- You do not comply with the provisions of the medical certification requirement.
- You do not comply with the provisions of the Company's Return to Work Program.

- You are terminated or leave the Company.
- You are confined for any reason in a penal or correctional facility.
- You return to work at the Company as a hiring hall employee or non-employee worker.
- Your death.

Claims and Appeals — Plans I, II, III and IV

Claims

You or your duly authorized representative may submit a claim related to LTD benefits to the third-party administrator in writing or via telephone. In order to be validly submitted and eligible for consideration, such a claim must be filed prior to your termination of employment and during the period of time in which you are otherwise eligible for benefits under the Plan. The third-party administrator will rule upon the claim within a reasonable period of time, but not more than 45 days after the third-party administrator's receipt of your claim.

Send your claim to:

Sedgwick Claims Management Services, Inc.
P.O. Box 14495
Lexington, KY 40512
Fax: (866) 856-4862

If you do not submit, with the initial claim for benefits, the documentation and information necessary to complete the claim, the third-party administrator will notify you and specify what information is missing and necessary for the third-party administrator to make a decision on the claim. Information necessary for the third-party administrator to make a decision on the claim generally includes (i) supporting evidence of a medical disability that precludes you from performing the normal duties of your base classification or, to the extent applicable, any job at the Company you are skilled and qualified to perform, and (ii) any other relevant and reasonable information or documentation requested by the third-party administrator that it communicates to you.

You will have until the expiration of the initial 45-day deadline (i.e., 45 days from the date of the third-party administrator's receipt of your claim) to provide needed information (unless you and the third-party administrator agree to allow additional time for you to submit information, as described below). This 45- day period may be extended for up to 30 days if the third-party administrator determines that the extension is necessary due to matters beyond the control of the Plan, including if you request additional time to provide additional supporting medical evidence of disability beyond what was originally submitted and the third-party administrator grants such request (in which case the third-party administrator will provide you a date by which you should supply the requested information). The third-party administrator will notify you of the reason for the delay prior to expiration of the initial 45-day period and give a date by which the third-party administrator expects to render its decision. If, prior to the end of the 30-day extension period, the third-party administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within the 30-day extension period, the period for making the determination may be extended for up to an additional 30 days. The third-party administrator will notify you of the reason for the delay before the expiration of the first 30-day extension period and give a date by which the third-party administrator expects to render its decision. Any notice of extension will explain the standards on which entitlement to Plan benefits is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. If an extension is due to your failure to submit information necessary to decide a claim, the period for making the determination will be tolled from the date on which the notification of extension is sent to you until the earlier of the date you respond to the request or the date that is 45 days after the date the notification is sent.

The period of time within which a decision is required to be made begins at the time a claim is filed in accordance with these procedures, without regard to whether all the information necessary to make a decision accompanies the filing.

If a claim for benefits under the Plan is subject to an adverse benefit determination in whole or in part, the third-party administrator will furnish to you a written or electronic notice. The notice will be provided in a culturally and

linguistically appropriate manner and will be written in a manner calculated to be understood by you. The notice will include:

- The specific reason(s) for the adverse benefit determination;
- A reference to the specific Plan provision(s) on which the adverse benefit determination is based;
- A description of any additional material or information necessary for you to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures (including the time limits applicable to such procedures) and a statement of your right to bring a civil action under Section 502(a) of ERISA if the claim is subject to an adverse benefit determination on review under the Plan's review procedures;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made by the Social Security Administration regarding you that you present to the Plan;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist; and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

If your claim for Plan benefits is subject to an adverse benefit determination for any reason other than not meeting the eligibility period, any further claim for Plan benefits for the same disability occurring on the same date of disability will not be considered, and your recourse with regard to that disability will be limited to having the opportunity to file an appeal of the adverse benefit determination (in accordance with the appeal procedures described below).

Appeals

If you are not satisfied with the written notice provided by the third-party administrator, you or your duly authorized representative may request a full and fair review through submitting an appeal. There are two levels of appeal for each claim subject to an adverse benefit determination: a first-level appeal through the third-party administrator and a second-level appeal through the Employee Benefit Appeals Committee ("EBAC"). The procedures governing each level of appeal are set forth below.

First-Level Appeal

If your claim is subject to an adverse benefit determination, you or your duly authorized representative may request a full and fair review by submitting a written first-level appeal to the third-party administrator's appeals unit within 180 days of receiving notice of such adverse benefit determination.

Send your first-level appeal to:

Sedgwick National Appeals Unit (NAU)
P.O. Box 14446
Lexington, KY 40512
Fax: (888) 488-9536

Review of the first-level appeal will be conducted by the third-party administrator. No deference will be given to the initial adverse benefit determination. The decision on review will not be made by the same individual who made the adverse benefit determination that is the subject of the first-level appeal, or a subordinate of that

individual. You may submit written comments, documents, records and other information relating to the first-level appeal. The third-party administrator will take into account all comments, documents, records and other information that you submit with the first-level appeal regardless of whether such information was submitted or considered in a prior benefit determination. You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim.

The third-party administrator will rule upon the first-level appeal within a reasonable period of time, but not more than 45 days after its receipt of the first-level appeal. If special circumstances require an extension of time for processing the first-level appeal, the third-party administrator may take up to an additional 45 days. The third-party administrator will notify you of the reason for the delay prior to expiration of the initial 45-day period and give a date by which it expects to render its decision.

The period of time within which a decision is required to be made begins at the time a first-level appeal is filed in accordance with these procedures, without regard to whether all the information necessary to make a decision accompanies the filing. If an extension is due to your failure to submit information necessary to make a determination, the period for making the determination will be tolled from the date on which the notification of extension is sent to you until the earlier of the date you respond to the request or the date that is 45 days after the date the notification is sent.

The third-party administrator will furnish to you a written or electronic notice of its benefit determination on review. The notice will be provided in a culturally and linguistically appropriate manner and will be written in a manner calculated to be understood by you. If a first-level appeal is denied in whole or in part, the notice will include:

- The specific reason(s) for the denial of the appeal;
- A reference to the specific Plan provision(s) on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- A description of the Plan's remaining review procedures (including the time limits applicable to such procedures) and a statement of your right to bring a civil action under Section 502(a) of ERISA if the appeal is denied following exhaustion of such review procedures;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made by the Social Security Administration regarding you that you present to the Plan;
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the appeal or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.

Before the third-party administrator can deny a first-level appeal, it will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date by which notice of any denial is required to be provided to give you a reasonable opportunity to respond prior to such date.

Before the third-party administrator can deny a first-level appeal based on a new or additional rationale, it will provide you, free of charge, with the rationale as soon as possible and sufficiently in advance of the date by which notice of any denial is required to be provided to give you a reasonable opportunity to respond prior to such date.

In deciding a first-level appeal of an adverse benefit determination based in whole or in part on a medical judgment, the third-party administrator will consult with a health care professional who has appropriate training

and experience in the field of medicine involved in the medical judgment and was not consulted in connection with a prior adverse benefit determination nor a subordinate of that individual. If requested by you, the third-party administrator will identify the medical or vocational experts whose advice was obtained in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the decision on review.

Second-Level Appeal

If your first-level appeal is denied in whole or in part, you or your duly authorized representative is required to submit a written second-level appeal to the EBAC at the address specified below before you may file a lawsuit. The second-level appeal must be submitted to the EBAC within 60 days of the date you received notification of the denial of the first-level appeal.

Send your second-level appeal to:

Pacific Gas and Electric Company
ATTN: Benefits Department EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

No special form or format is required in submitting a written second-level appeal; you may present the pertinent facts and other information in any words that you believe will further your second-level appeal.

Review of the second-level appeal will be conducted by the EBAC. No deference will be given to prior adverse benefit determinations. The decision on review will not be made by the same individual(s) who made the prior adverse determination on the claim or denied the first-level appeal, or a subordinate of such individual(s). You may submit written comments, documents, records and other information relating to the second-level appeal. The EBAC will take into account all comments, documents, records and other information that you submit with the second-level appeal regardless of whether such information was submitted or considered in a prior benefit determination or first-level appeal. You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim.

The EBAC will rule upon the second-level appeal within a reasonable period of time, but not more than 45 days after its receipt of the second-level appeal. If special circumstances require an extension of time for processing the second-level appeal, the EBAC may take up to an additional 45 days. The EBAC will notify you of the reason for the delay prior to expiration of the initial 45-day period and give a date by which it expects to render its decision.

The period of time within which a decision is required to be made begins at the time a second-level appeal is filed in accordance with these procedures, without regard to whether all the information necessary to make a decision accompanies the filing. If an extension is due to your failure to submit information necessary to make a determination, the period for making the determination will be tolled from the date on which the notification of extension is sent to you until the earlier of the date you respond to the request or the date that is 45 days after the date the notification is sent.

The EBAC will furnish to you a written or electronic notice of its benefit determination on review. The notice will be provided in a culturally and linguistically appropriate manner and will be written in a manner calculated to be understood by you. If a second-level appeal is denied in whole or in part, the notice will include the same information that was included in the notice issued with respect to the first-level appeal denial (described above) and will identify the contractual limitations period that applies to your right to bring an action under section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the claim.

Before the EBAC can deny a second-level appeal, it will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date by which notice of any denial is required to be provided to give you a reasonable opportunity to respond prior to such date.

Before the EBAC can deny a second-level appeal based on a new or additional rationale, it will provide you, free of charge, with the rationale as soon as possible and sufficiently in advance of the date by which notice of any denial is required to be provided to give you a reasonable opportunity to respond prior to such date.

In deciding a second-level appeal of an adverse benefit determination based in whole or in part on a medical judgment, the EBAC will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and was not consulted in connection with a prior adverse benefit determination or first-level appeal nor a subordinate of such individual(s). If requested by you, the EBAC will identify the medical or vocational experts whose advice was obtained in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the decision on review.

Bargaining Unit Employees

Instead of electing to use the appeals steps, as described above, a union-represented employee may use the grievance or adjustment procedure of the appropriate collective bargaining agreement to resolve any dispute concerning any question of service, status, or membership under the Plan instead of using the Plan's procedures relating to first-level appeals and second-level appeals. Notwithstanding the foregoing, the use of any such grievance or adjustment procedure will not impair or interfere with your exercise of any rights under ERISA.

Violations of Claims and Appeals Procedure

You have the right to request a written explanation of any violation of these procedures. The Plan will provide an explanation within 10 days of the request, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies under the Plan to be deemed exhausted.

Exhaustion of Claims and Appeals Procedure Required in All Cases

The claims review procedures described above are the exclusive claims administrative procedures provided under the Plan. You must exhaust these claims review procedures with respect to any claim, alleged violation of ERISA or any other law, or remedy sought under any provision of ERISA or any other law, that relates in any way to the Plan before taking action in another forum.

Legal Action

You or your representative may not bring action with respect to a claim, alleged violation of ERISA or any other law, or remedy sought under any provision of ERISA or any other law, that relates to the Plan in any way in any other forum after the earliest of the date that is:

- one year from the date of exhaustion of the Plan's claims review procedures described above; or
- one year from the latest date on which a second-level appeal is permitted to be filed with the EBAC after the issuance of a denial with respect to a first-level appeal (i.e., within 60 days of receipt of a first-level appeal denial notification).

Any such action must be filed in the Federal District Court for the Northern District of California.

The requirements for filing an action on a claim, alleged violation of ERISA or any other law, or remedy sought under ERISA or any other law, that relates to the Plan are in no way a waiver of the requirement to exhaust the claims review procedures under the Plan.

Workers' Compensation

Pacific Gas and Electric Company, and PG&E Corporation and its covered affiliates (referred to collectively as "Company" in this section) are self-insured under state law, and in addition, Pacific Gas and Electric Company maintains self-insurance under the federal Longshore and Harbor Workers' Compensation Act, to provide Workers' Compensation benefits for employee injury or illness which arises out of and occurs in the course of work. To the extent an employee has been authorized to work and reside outside of California, the Company has precured Workers' Compensation coverage for those authorized employees. The Workers' Compensation program provides you with partial income replacement in the form of disability benefits and medical treatment. In the event of a work-related death, the program provides your dependents with death and burial benefits. The Workers' Compensation program is administered by the Pacific Gas and Electric Company Workers' Compensation Department.

You should note that the Company is not responsible for Workers' Compensation benefits for any injury or illness that results from your voluntary participation in any off-duty recreational, social or athletic activity that is not part of your work-related duties.

Contractors and agency workers are not entitled to the Company's Worker's Compensation benefits.

Procedures in the Event of an Industrial Injury or Illness

Work-Related Injury or Illness

In an emergency, go to the nearest emergency medical facility and, as soon as possible, contact the Workers' Compensation Helpline (Helpline) at 415-973-8700, option 2.

The Company's extensive safety program helps you to avoid injury. However, in the event of an industrial injury or illness, you will be provided with all medical care that is reasonably required to cure or relieve the effects of the injury or illness. Every reasonable effort will be made to minimize the extent and duration of your injury or illness and to continue the appropriate medical care. In addition, you will be provided ongoing contact with the Company's Workers' Compensation Representatives, timely referrals to medical specialists and the Company's Return to Work program, as reasonably necessary, and additional other benefits which exceed the requirements of state law.

Every industrial injury or illness must be reported to your supervisor as soon as possible. After your supervisor has been notified, you should call the 24/7 **Nurse Care Line at 1-888-449-7787**. An intake representative will confirm the basic contact information and incident details, and then transfer you to a nurse or doctor who will assess the situation, and you will either receive self-care recommendations or be referred to a doctor within the Company's medical provider network. The incident will be reported entirely over the phone, and you and your supervisor will receive an email that documents the call, and will serve as the official incident report. No personal medical information will be shared with your supervisor or PG&E during this process. The Company will provide you a Workers' Compensation claim form if applicable to your situation.

Pre-Designation of Personal Physician

If a Personal Physician Treatment Request Form (Form #62-4068) is on file prior to the industrial injury or illness, you may be treated by your own physician instead of a doctor in the Medical Provider Network (MPN).

- Due to changes in Workers' Compensation law regarding pre-designation of a personal physician, the current form you should submit is the Notice of Pre-Designation of Personal Physician (Optional DWC Form 9783, dated March 1, 2007).
- The Company will honor old Request forms on file, unless your previous designation was a chiropractor or acupuncturist. In such cases, you should complete a new Request form pre-designating a regular physician who is not a chiropractor or acupuncturist.
- If you wish to submit a new Request form, or make changes to an existing form, a new form should be completed to document those changes.

Definition of Personal Physician

If you have a Personal Physician Treatment Request Form on file prior to the date of injury or illness, you have the right to be treated by that physician from the date of injury or illness.

A personal physician must meet all of the following conditions:

- The physician is your regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.
- The physician is your primary care physician and has previously directed your medical treatment, and retains your medical records, including your medical history. "Personal physician" includes a medical group, if the medical group is a single corporation or partnership composed of licensed Doctor of Medicine or osteopathy that operates an integrated multi-specialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries.

Medical Provider Network (Panel of Physicians)

The Company has partnered with Kaiser on the Job (KOJ) and Anthem Blue Cross, a national managed-care company, to develop the PG&E/Anthem Blue Cross Medical Provider Network (MPN).

For non-emergency situations, you may use either the Network link or contact your Workers' Compensation Representative (WCR) for a referral to an MPN provider for initial treatment. If you are temporarily working outside the MPN service area you may get treatment from a doctor of your choice. The Network link is a partial listing of the MPN, developed to assist in the initial referral to an appropriate provider.

If you would like to review, receive, or access the complete MPN provider directory, you can:

- visit the MPN website at pge.com/mpn, or
- call Kaiser on the Job at **1-888-565-9675 or** Anthem Blue Cross at **1-866-700-2168**

You may also contact PG&E's Medical Access Assistant (MAA) by email at PGEMAA@anthemwc.com or by calling **1-844-752-1145**.

If you have difficulty getting an appointment or need any assistance in locating an MPN provider you may contact your WCR or the Safety and Health Helpline at 415-973-8700.

Supplemental Benefits for Industrial Injury Plan

The Supplemental Benefits for Industrial Injury Plan is designed to provide employees of Pacific Gas and Electric Company with supplemental income benefits — above your Workers' Compensation disability income — if you sustain an injury or illness on the job and are entitled to temporary disability benefits. ("Company," in this Supplemental Benefits for Industrial Injury Plan section, means Pacific Gas and Electric Company only.)

You are not eligible for benefits from the Supplemental Benefits for Industrial Injury Plan if you are a contract or agency worker, or an employee of PG&E Corporation or PG&E Corporation Support Services II, Inc.

When Benefits Begin

Benefits can begin on the first lost workday after an injury or illness occurs. Plan benefits can continue as long as you are entitled to Workers' Compensation temporary disability benefits, or within the limits prescribed by law.

Benefits from the Supplemental Benefits for Industrial Injury Plan are not automatic. To apply for benefits, you must complete and sign the "Request and Application for Permanent Disability Advances Paid as Supplemental Benefits" form.

If your disability turns out to be permanent, all or some of the Supplemental Benefits paid during your absence from work may be deducted from any permanent disability benefits you are entitled to receive under Workers' Compensation. For injuries or illnesses occurring on or after January 1, 1991, the sum of Supplemental Benefits, net of taxes, paid during the first 182 days of absence will constitute a credit against permanent disability benefits.

How Much the Plan Pays

Combined with other disability benefits, the Plan assures you of an income equal to:

- 75% of your basic weekly wage rate for injuries/illnesses occurring on or after January 1, 2000 (no change at the 183rd day);
- 85% of your basic weekly wage rate for the first 182 days you are absent from work, and 66⅔% of your basic weekly wage rate starting on the 183rd day you are absent from work for injuries/illnesses occurring on or after January 1, 1991, through December 31, 1999; or
- 85% of your basic weekly wage rate for the first 182 days you are absent from work, and 75% of your basic weekly wage rate starting on the 183rd day you are absent from work for injuries/illnesses occurring on or after January 1, 1983, through December 31, 1990.

Your "basic weekly wage rate" means your regular pay and excludes overtime, premium pay, bonuses or other pay. In calculating your benefit amount, the Supplemental Benefits for Industrial Injury Plan will deduct any payments you are entitled to under the Workers' Compensation and Insurance Chapters of the California Labor Code or the State Disability Insurance plan. To the extent an employee has been authorized to work and reside

outside of California, the Supplemental Benefits for Industrial Injury Plan will deduct any payments you are entitled to under that state's relevant Workers' Compensation Act.

When Benefits End

Your benefits from the Supplemental Benefits for Industrial Injury Plan will end on the earliest of the following events:

- You are released to return to your usual and customary job.
- You refuse an offer of modified or transitional duty work at the Company.
- You refuse work with the Company under a rehabilitation plan.
- You accept a job outside of the Company.
- You are medically rehabilitated.
- Your temporary disability benefits end, due to the two-year time limit, or for any other reason.
- Your employment status is terminated for any reason.
- You transfer to the Long-Term Disability payroll.
- You retire.
- Your death.

Returning to Work

If you are disabled, the Company will make every effort to help you return to work as soon as you are able. Depending on your medical condition and the availability of appropriate jobs, the Company may ask you to perform transitional duties temporarily for a duration that, in most cases, will not exceed six months, until you are released to full duties and/or your medical condition reaches a "maximum medical improvement" status. While on transitional duty, you will be paid at the rate of pay for your regular position. Your treating physician must approve the transitional duty and will help the Company decide when you can resume your regular duties.

Claims and Appeals

Claims

Benefits from the Supplemental Benefits for Industrial Injury Plan are not automatic. To apply for benefits, you must complete and sign the "Request and Application for Permanent Disability Advances Paid as Supplemental Benefits" form that you will receive from the Workers' Compensation Department upon becoming disabled due to an industrial injury.

If you submit a claim that is incomplete, you will be notified that an extension is needed and the additional information necessary to make a decision on your claim. Workers' Compensation (Claims Administrator) will provide this notice not more than 45 days after receipt of your claim. You will have 45 days to provide the other information necessary for the Claims Administrator to make a decision. The Claims Administrator will make a decision on the claim within 30 days after receipt of this information or within 30 days after the expiration of your 45-day deadline to provide the information, whichever is earlier.

Once a full and complete claim has been submitted, the Claims Administrator may, due to matters beyond the Plan's control, extend its review of your claim for up to two additional 30-day periods if additional information is still needed. You must be notified before the end of the initial 45-day period, if an initial extension of up to 30 days is required, and be told why the extension is necessary and when the Claim Administrator expects to render its decision. If an additional 30-day extension period is required, you must be notified before the end of the first 30-day extension period and told why the second extension is necessary and when the Claim Administrator expects to render its decision.

If you believe you have been denied a benefit to which you may be entitled, you may appeal the claim to the Workers' Compensation Department within 45 days after you receive the denial by writing to the following address:

Pacific Gas and Electric Company
Workers' Compensation Department
300 Lakeside Drive
Oakland, CA 94612

No special form or format is required in submitting a written appeal; you may submit written comments, documents, records and other information relating to your claim. You may also request, free of charge, access to, or copies of, all documents, records and other information relevant to your claim for benefits. The review will take into account all comments, documents, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered at the initial benefit determination. Please note, however, that it is the obligation of the Workers' Compensation Department to administer the Plan fairly, consistently, and in accordance with the provisions of the Plan.

If the Claim Administrator denies your claim, you will receive a written response which will include:

- the specific reason(s) for the denial of the claim;
- a reference to the Plan provision(s) which apply to the denial;
- a description of any additional material or information necessary for a participant or beneficiary to perfect the claim and an explanation of why such material or information is necessary; and
- a description of the Plan's review procedures and the time limits applicable to such procedures.

Life and Accident Insurance Plans

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

- $10,000 of Company-paid basic term life insurance coverage;
- The option to purchase additional, supplemental term life insurance coverage for yourself, your spouse or registered domestic partner and your children or the children of your spouse/registered domestic partner;
- $10,000 of Company-paid basic accidental death and dismemberment (AD&D) insurance, depending on your job level;
- The option to purchase additional, voluntary AD&D insurance coverage for yourself, your spouse or registered domestic partner, and your children or the children of your spouse/registered domestic partner;
- Helicopter insurance benefits for employees who perform helicopter patrolling and certain other work while riding in a helicopter; and
- Business travel insurance coverage.

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation.

Cost of Coverage

The Company pays the full cost for $10,000 of Group Life Insurance Plan coverage, as well as for $10,000 of Accidental Death and Dismemberment (AD&D) Insurance coverage — this is your basic coverage. If you want to enroll for Supplemental Life and/or Voluntary AD&D Insurance coverage, you pay for that coverage with convenient after-tax salary deductions.

In addition to the cost for your basic life and basic AD&D insurance coverage, the Company pays the full cost of premiums for business travel insurance.

Imputed Income from Your Life Insurance Coverage

The value of your group life insurance over $50,000 (as determined by IRS tables) is includible as additional income on your W-2 as imputed income. This "imputed income" is based on your age at rates set by the IRS. Imputed income is calculated each month and is automatically included in the wages shown on your pay statement as well as your annual W-2 form.

Claims Administrators and Insurers

- MetLife Insurance Company (MetLife) is both the claims administrator and the insurer of the life insurance and accidental death and dismemberment benefits.
- Zurich and W. R. Berkley Corporation are both the claims administrators and insurers for the helicopter insurance benefit.

- ACE American Insurance Company (ACE) is both the claims administrator and the insurer of the business travel insurance benefit.

Additional Information

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

Plan Documents and Administration

The plan documents for The Pacific Gas and Electric Company Group Life Insurance Plan and The PG&E Corporation Business Travel Insurance Plan incorporate the terms of this Summary of Benefits Handbook that pertain to the relevant plan as well as any applicable Summaries of Material Modifications and insurance policies.

Unless otherwise noted, if there is a conflict between a plan document and this Summary of Benefits Handbook, the plan document controls. If the plan document is silent on a specific issue, then this Summary of Benefits Handbook controls on that issue. However, with respect to fully insured benefits, the terms of the certificate of insurance or other similar document control when describing specific benefits that are covered or insurance-related terms.

The Employee Benefit Committee of PG&E Corporation has the discretionary authority to interpret and construe the terms of the plan, to resolve any conflicts or discrepancies between documents and to establish rules which are necessary or desirable for the administration of the plan. Notwithstanding the foregoing, the relevant insurer has the authority to construe and interpret the terms of the certificate of insurance or other similar document.

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Group Life Insurance

The Company automatically provides you with $10,000 in Basic Life Insurance coverage. You may also purchase supplemental life insurance coverage for yourself, your spouse or registered domestic partner, and/or your children and/or the children of your spouse or registered domestic partner, which you pay for through after-tax salary deductions.

The amount of life insurance you need may depend on several factors, including your age, family status and other financial resources.

Employee Supplemental Life Insurance

The Group Life Insurance Plan offers you multiple levels of supplemental life insurance coverage from which to choose, up to a maximum of $1,000,000, as follows:

- Standard Life ($50,000)
- Life 1 (1 times your base annual pay)
- Life 2 (2 times your base annual pay)
- Life 3 (3 times your base annual pay)
- Life 4 (4 times your base annual pay)
- Life 5 (5 times your base annual pay)
- Life 6 (6 times your base annual pay)

The supplemental coverage amounts are in addition to the $10,000 of Company-provided Basic coverage.

Your "base annual pay" means your annualized base rate of pay and does not include overtime or any other special compensation. Your calculated supplemental insurance amount will be rounded to the next higher $1,000. You pay for Supplemental Life Insurance with after-tax payroll deductions.

Effect of an Increase or Decrease in Rate of Pay

The amount of your supplemental life insurance will automatically adjust whenever you receive a raise that is other than temporary. The new amount will go into effect on the first day of the calendar month following the date of change, unless you are absent from work on that day because of illness or injury. In that case, your new coverage amount will become effective when you return to work.

Coverage for Intermittent Employees

If you are a regular intermittent employee who works on a non-scheduled, part-time basis and you meet all of the Group Life Insurance Plan's eligibility requirements, you will receive life insurance coverage in the amount of $10,000.

If you transfer from a full-time to an intermittent job, you may retain the amount of coverage you had immediately prior to your transfer to intermittent status, or you may decrease your coverage to $10,000.

Dependent Life Insurance

You may elect life insurance for your spouse or registered domestic partner and/or your children and/or the children of your spouse or registered domestic partner.

Spouse/Registered Domestic Partner Life Insurance

When you elect Supplemental Life for yourself, you may elect Supplemental Life Insurance coverage for your spouse or registered domestic partner. If elected within 90 days of eligibility, coverage of up to $25,000 is

automatically approved by MetLife Insurance Company — no evidence of good health is required. If elected more than 90 days after your initial eligibility date, a Statement of Health will be required. The coverage amount for your spouse's or registered domestic partner's benefit cannot be more than 50% of your total Basic and Supplemental Life Insurance coverage amounts. If you elect spouse/registered domestic partner coverage, your contributions are paid with after-tax dollars from your pay.

Coverage	Benefit Amount
Spouse or Registered Domestic Partner	▪ $10,000 ▪ $25,000 ▪ $50,000 ▪ $75,000 ▪ $100,000

Dependent Child Life Insurance

You may elect dependent child life insurance coverage for your children and/or the children of your spouse or registered domestic partner. You do not need to elect Supplemental Life for yourself in order to elect coverage for your eligible child(ren) and you may enroll or increase coverage at any time, without evidence of good health. If you elect dependent child life insurance coverage, your contributions are paid with after-tax dollars from your pay.

Coverage	Benefit Amount
Child(ren)	You may purchase: ▪ $5, 000, $10,000 or $25,000 for each dependent child from the age of 14 days to age 26. ▪ $1,000 for any child who is younger than 14 days old.

You are automatically the beneficiary of any life insurance benefits purchased for your dependent(s). Benefits are not payable if your spouse, registered domestic partner or dependent child commits suicide within two years of election of benefits; if applicable, any premiums that you paid will be refunded.

If, after electing dependent child life insurance coverage, you acquire a new dependent (such as a newborn or adopted child), the new dependent will automatically be covered under the policy at no additional cost. However, if you want the new dependent to be a beneficiary under any of your life/accident insurance policies, you must add the dependent's name(s) to the list of beneficiaries of the policy(ies). To do so, call the PG&E Benefits Service Center at **1-866-271-8144**, or log on to PG&E's Benefits Portal (accessible through PG&E@Work For Me or mypgebenefits.com) to update your beneficiaries online.

Eligibility, Enrollment and Cost

You are eligible to participate in the life insurance plan the first of the month after you have completed six months of employment and attained Regular status and are actively at work, if you are a full-time or part-time union-represented employee of the Company. You are not eligible for this life insurance plan if you are a contractor, agency worker, hiring hall employee, or retired employee. Intermittent employees (except as noted) and other temporary employees who are not expected to become regular employees are also not eligible for coverage.

Enrollment

Your Company-provided Basic Life Insurance coverage in the amount of $10,000 automatically becomes effective on the first of the month following the date on which you first satisfy the eligibility requirements. Any Supplemental Life insurance you elect will go into effect the first day of the month following your enrollment, provided you are eligible and enroll within 90 days of the date on which you first satisfy the eligibility

requirements. For example, if you were hired on February 1 as a union-represented employee, you satisfy the eligibility requirements on August 1 and you complete the enrollment process on August 15, you would be eligible for life insurance, above the Company-provided Basic Life, on September 1. If you enroll in Supplemental Life Insurance before you are actually eligible (e.g., before you attain regular status), your coverage will not take effect until the first of the month following the date on which you satisfy the eligibility requirements.

To enroll in Supplemental Life Insurance, log on to PG&E's Benefits Portal via computer or smart device (accessible through mypgebenefits.com), or call the PG&E Benefits Service Center at **1-866-271-8144**. If you do not complete the enrollment process when initially eligible, you will be assigned Basic Life Insurance coverage in the amount of $10,000. You may increase your level of coverage by enrolling for Supplemental Life Insurance coverage at any time during the year. After your initial eligibility period, you will only be allowed to elect Supplemental Life Insurance coverage for up to two times annual pay without providing evidence of good health.

You must be actively at work on or after the effective date of your enrollment for coverage changes to take effect (e.g., if you are on sick leave or a leave of absence without pay, any changes to your life insurance coverage will not take effect until you return to work).

Actively at Work

"Actively at work" means you are performing all of the usual and customary duties that pertain to your work at the place where it is normally done, or where it is required to be done by your employer.

Cost of Coverage

The monthly cost for supplemental coverage depends on your age. You should refer to your personalized information for employee, spouse or registered domestic partner, and/or child(ren) coverage when you log on to PG&E's Benefits Portal.

How Your Benefit Is Paid

Life insurance benefits are generally paid to your beneficiary in one sum. Unless the beneficiary requests payment by check, MetLife may pay life insurance benefits by establishing an interest-bearing account that provides the Beneficiary with immediate access to the full benefit amount, or by another method that provides immediate access to the full benefit amount, in accordance with the terms of the MetLife certificate. For information on installment payments, call MetLife Insurance Company at **1-800-638-6420**.

Your Beneficiary

Your beneficiary is the person or persons to whom a benefit will be paid in the event of your death. Your beneficiary can be anyone you choose, and you can name more than one beneficiary. In addition, you may name a trust, charity or estate. For spouse, registered domestic partner, and child life insurance benefits, you are the beneficiary.

More than One Beneficiary

If you designate more than one person as your beneficiary, each will share in the benefits equally, unless you have designated specific percentages for each beneficiary.

If a benefit is payable to a minor, the benefits may be paid to a Court Appointed Guardian of Person and Property of the Minor's Estate, or deposited into a MetLife interest-bearing account that becomes accessible to the minor when the minor reaches age 18. Before naming a minor as your beneficiary, we suggest that you consult with your legal advisor.

Designating or Changing Your Beneficiary

To establish, change or review your beneficiary designations, log on to PG&E's Benefits Portal, accessible via PG&E@Work For Me or mypgebenefits.com, and update your Beneficiary information online. It is important that you always keep your beneficiary designations up to date. This is your responsibility. You may change your beneficiary designations at any time. If you enter your designations/changes into PG&E's Benefits Portal account, your updates are effective on the date on which you enter the information online.

Any beneficiary designation or change will not affect any payment MetLife Insurance Company makes or actions it takes before the notice of designation or change is submitted and processed.

Death of a Beneficiary

A person's rights as a beneficiary end if that person dies:

- before your death occurs; or
- at the same time your death occurs; or
- within 24 hours of your death.

The share for that person will be divided among the surviving persons you have named as beneficiary, unless you have chosen otherwise.

No Beneficiary at Your Death

If no beneficiary should survive you, your benefit will be paid to the first survivor(s) in this order:

- your spouse (also includes registered domestic partner);
- your eligible children;
- your parents; or
- your eligible siblings.

If there is no surviving relative in any class, the benefit amount will be payable to your estate.

Estate Planning

Managing your assets and planning how your assets will be distributed after your death can give you peace of mind and help you make sound financial plans throughout your career and your lifetime. Assets may include items such as property, real estate and retirement accounts. Collectively, your assets make up your estate.

Your estate plan may include healthcare directives and a will, a trust, or both. A well-planned estate can give you the comfort of knowing that if there is an untimely death, no one will have to scramble for paperwork at their time of utmost grief. Planning your estate can help your family avoid probate and unnecessary financial burdens in the short and long term.

Contact the **Employee Assistance Program at 1-888-445-4436** to request a trusts and estates attorney in your area. The first 30-minute consultation is no cost to you, and if you decide to hire the attorney, you will receive a discount from the usual fee.

Will Preparation Services

If you elect supplemental life insurance coverage, you and your spouse or registered domestic partner will have access to will preparation services offered by MetLife Legal Plans, a MetLife Insurance Company affiliate. When you use a participating attorney, the attorney fees are fully covered for preparing or updating a will, including testamentary trusts within the will, such as trusts for minor children and charitable trusts that take effect after death.

Will preparation services may include preparation and updates of wills, living wills, powers of attorney, advance healthcare directives, and related estate planning documents, as permitted under applicable law. **Living trusts and tax planning services are not included.** Services are subject to state availability and may vary by jurisdiction.

You can call MetLife Legal Plans at **1-800-821-6400** and a client service representative will help you locate a participating attorney in your area. You will be asked to provide your Social Security number and PG&E's policy number: 74300.

You also have the flexibility of using a non-participating attorney and being reimbursed for covered services according to a set fee schedule. To be eligible for reimbursement, you must call MetLife in advance of your consultation, provide PG&E's policy number, and request a case number. However, if you use a non-participating attorney, you must pay the attorney's fee directly, then provide proof of payment to MetLife Legal Plans, along with a claim for reimbursement. You will be reimbursed for the attorney's services up to the amount you paid for

the attorney's services or the amount customarily reimbursed for such services by Metlife Legal Plans, whichever is less.

Documents such as living wills and powers of attorney are also included in the will preparation service.

Estate Resolution Services

If you elect supplemental life insurance coverage, you and your spouse or registered domestic partner will have access to MetLife Estate Resolution Services at no additional cost to you. A MetLife Legal Plan attorney will consult with your beneficiaries by phone or in person about the probate process for your estate. The attorney will assist your executor or administrator with probate-related legal services, in accordance with the covered services provided under the Estate Resolution Services program. These services provide valuable financial and administrative support for your family's probate needs. You can call MetLife Legal Plans at **1-800-821-6400** to help you locate a participating attorney in your area. You can also use a non-participating attorney and be reimbursed for covered services according to a set fee schedule. Estate Resolution Services cover attorney fees for eligible probate-related legal services only. **Court costs, filing fees, recording fees, witness fees, transcripts, appraisals, and other third-party expenses are not covered.** Services are provided through MetLife Legal Plans and are subject to state availability and applicable law.

Accelerated Benefit Option (ABO)

An early cash payment option, called the Accelerated Benefit Option (ABO), is included under the Group Life Insurance Plan. This cash payment option allows an employee, spouse or registered domestic partner who is terminally ill and whose death is expected within one year or less to receive a portion of his or her life insurance coverage. You must have at least $10,000 in Basic, Supplemental or Spouse/Registered Domestic Partner life insurance coverage to qualify for this option.

The following points briefly outline some of the provisions of the ABO:

- Benefits provide a cash payout of up to 80% of life insurance (basic and supplemental) coverage.
- Payment of an ABO is subject to an independent medical review and approval by Metropolitan Life Insurance Company, and is governed by applicable state law. Accelerated benefits may have tax consequences and may affect eligibility for public assistance programs, such as Medicaid or Supplemental Security Income (SSI). You are encouraged to consult with a tax advisor or legal advisor regarding the potential impact of receiving accelerated benefits.
- This is a one-time election option.
- The maximum payout amount is $8,000 for Basic Life Insurance, $500,000 for employee supplemental life insurance, and $80,000 for spouse or registered domestic partner supplemental life insurance.
- The balance of life insurance coverage is "frozen" and paid out to the designated beneficiary at the time of the employee's, spouse's or domestic partner's death.
- All decisions made by MetLife Insurance Company to grant or deny this benefit are final.
- Exclusions:
  - You are not eligible for the ABO if you have assigned your life insurance coverage (see "Assignment of Benefits" under *Group Life Insurance* for additional information), or
  - The amount of your benefit is less than $10,000.

For further information about the ABO, please call the PG&E Benefits Service Center at **1-866-271-8144**. Questions regarding the status of an ABO claim should be directed to MetLife Insurance Company at **1-800-638-6420**.

Assignment of Benefits

You have the right to assign your life insurance benefits to someone else as a gift or as a viatical assignment, but only when a viatical assignment is allowed by state law. This means you can transfer or assign all rights, title, interest and ownership, both for the present and future which includes:

- the right to make any contributions required to keep the benefits in force,
- the privilege of obtaining an individual policy of life insurance (conversion), and
- the right to designate or change the beneficiary designation.

Assignment of benefits is a complicated financial and legal matter. If you are considering an assignment, please contact the PG&E Benefits Service Center at **1-866-271-8144** for additional information.

Viatical Assignment

An option for terminally ill employees is to sell their life insurance for cash to viatical settlement companies that buy life insurance policies. Viatical settlement companies offer different levels of cash payment options and the criteria for qualifying varies from one company to another. You must contact a viatical settlement company directly to obtain information regarding its program options.

For further information about the viatical option, please call the PG&E Benefits Service Center at **1-866-271-8144**.

Changing the Level of Your Coverage

You can increase or decrease the amount of your life insurance coverage, or cancel coverage, at any time. If you increase coverage, however, you will be required to complete and submit a Statement of Health form to MetLife Insurance Company for all elections over two times your base annual pay. If you are not actively at work, the change will not become effective until you return to work. See "Actively at Work" under "Eligibility, Enrollment, and Cost."

If you elect to increase your Group Life Insurance Plan coverage to an option of up to two times your base annual pay, the increase is automatically approved by MetLife Insurance Company, and your cost of coverage will be based on the amount elected.

If you fail to submit evidence of good health, your coverage will be limited to two times your base annual pay.

If you make an election or elect any increase in coverage for your spouse or registered domestic partner after the initial 90-day eligibility period, your spouse or registered domestic partner will be required to submit evidence of good health to MetLife Insurance Company for approval. See "Evidence of Good Health" below for more details.

If you fail to submit evidence of good health when requested by Metropolitan Life, the election or increase for your spouse or registered domestic partner coverage will not go into effect.

Evidence of Good Health

During the initial eligibility period, you can elect supplemental life insurance coverage up to two times your base annual pay (and up to $25,000 coverage for a spouse or domestic partner) without evidence of good health. After the initial eligibility period, any requested increase in life insurance above two times your base annual pay (or any election or increase for a spouse or registered domestic partner) requires evidence of good health and approval by MetLife Insurance Company. If you elect an amount of coverage that requires approval, you will need to complete a Statement of Health form. The Statement of Health form may be completed online on PG&E's Benefits Portal as part of the enrollment process, or you can request a paper copy of the form from the PG&E Benefits Service Center. Paper Statement of Health forms should be returned to MetLife at the address indicated on the form.

If MetLife Insurance Company requires a physical examination in order to make its determination, the examination will be at your own expense. After MetLife Insurance Company receives complete information from you and your doctor (if required), you will receive notification of Metropolitan Life's decision to approve or deny

your request. If you fail to submit evidence of good health, your coverage will be limited to two times your annual pay (and/or any election or requested increase in coverage for your spouse or registered domestic partner will be denied.

Approval or Refusal

Once MetLife reviews your completed Statement of Health form, MetLife Insurance Company will notify you that they are either increasing your coverage to the level you requested, effective on the first day of the month following the approval date, or denying your request.

If approved, your life insurance coverage cost will change the first of the month following approval to reflect the increased contribution.

If your request is denied, your coverage will remain at the amount in effect prior to your request or two times your base annual pay, whichever is greater.

What Happens…

If You Take a Leave of Absence

If you are on a Company-approved leave of absence, your Basic Life Insurance coverage will remain in effect for the duration of the leave. Any Employee Supplemental Life Insurance and/or Dependent Life Insurance coverage will remain in effect, but you will be responsible for paying the premiums for the coverage(s). If you are receiving any type of PG&E pay while you are on leave, the premiums may be automatically deducted from the pay you receive.

If you'd like to redirect your VPDI pay, submit your request through:

- PG&E@Work For Me > About Me > My Pay or My Benefits > Benefits Redirect. While on leave, your access to the portal will remain enabled, even with your other PG&E network access disabled.

OR

- If you do not have computer access or are otherwise unable to log in to the portal, email **Benefits@pge.com** to request a Voluntary Plan Benefits Deduction Redirect Form.

If you are on an unpaid leave, your missed premiums will be suspended while you are on leave and then automatically deducted from your paycheck when you return to work. Note that these premiums will be taken from the first check.

If You Become Disabled

While you qualify for benefits from the Long-Term Disability Plan, your Basic and Supplemental Life Insurance coverage will continue at no cost to you. Your Dependent Life Insurance coverage will remain in effect, but you will be responsible for paying the premiums for the coverage. Such premiums, if applicable, will be deducted automatically from any Long-Term Disability (LTD) payments you receive from PG&E.

If You Retire

If you retire under the Company's Retirement Plan, you may be eligible for postretirement life insurance. For more information, you can access a copy of the Summary of Benefits Handbook for Retirees and Surviving Dependents online at mypgebenefits.com. You can also request the handbook by calling the PG&E Benefits Service Center at **1-866-271-8144**.

If applicable, you may also apply to convert any remaining amount of your Group Life Insurance coverage to an individual policy within 31 days of the date on which coverage ends. See "Converting Your Coverage to an Individual Policy."

When Coverage Ends

Your basic and supplemental life coverage under the Group Life Insurance Plan ends:

- At the end of the month in which you retire;
- At the end of the month in which you cease paying required premiums;
- At the end of the month in which you are no longer considered eligible for benefits;
- At the end of the month in which your employment ends (other than retirement); or
- If the benefit(s) under the Group Life Insurance Plan is terminated by the Company or the carrier.

Converting Your Coverage to an Individual Policy

If you terminate, retire from the Company, are no longer eligible for union-represented benefits, or your benefits are reduced due to a change in your employment with the Company, you, your spouse or registered domestic partner, and child(ren) covered under supplemental life insurance have the option of converting your lost Group Life Insurance Plan coverage to an individual insurance policy within 31 days after your coverage ends, without having to furnish evidence of good health. This option is called the "conversion privilege."

The new policy will become effective immediately upon approval by MetLife Insurance Company, as long as you have paid the first premium. To apply for an individual policy, contact MetLife Advice Line at **1-877-275-6387**.

If you do not apply to convert your life insurance to an individual policy and your death occurs within the 31-day conversion period, your beneficiaries will be entitled to receive life insurance proceeds for the full amount of coverage which was in effect on your last day of employment.

Accidental Death and Dismemberment (AD&D) Insurance

The Company automatically provides you with $10,000 in Basic Accidental Death and Dismemberment (AD&D) Insurance coverage. You may also purchase Voluntary Accidental Death and Dismemberment (Voluntary AD&D) coverage, which you pay for through after-tax salary deductions.

The amount of AD&D insurance you need may depend on several factors, including your age, family status and other financial resources.

Employee Voluntary AD&D Insurance

You can choose from multiple levels of Voluntary AD&D Insurance coverage, up to a maximum of $1,000,000, as follows:

- AD&D 1 (1 times your annual pay)
- AD&D 2 (2 times your annual pay)
- AD&D 3 (3 times your annual pay)
- AD&D 4 (4 times your annual pay)
- AD&D 5 (5 times your annual pay)
- AD&D 6 (6 times your annual pay)

The voluntary coverage amounts are in addition to the $10,000 of Company-provided Basic AD&D coverage.

Your "base annual pay" means your annualized base rate of pay and does not include overtime or any other special compensation. Your calculated Voluntary AD&D insurance amount will be rounded to the next higher $1,000. You pay for Voluntary AD&D coverage through after-tax payroll deductions.

Enrollment changes are allowed during the year, and benefit coverage continues during periods of an approved leave of absence in accordance with the same rules as life insurance.

Dependent Voluntary AD&D Insurance

You may elect Voluntary AD&D Insurance coverage for yourself, your spouse or registered domestic partner, and child(ren) as follows:

Coverage	Benefit Amount
Spouse or Registered Domestic Partner and Child(ren)	An amount equal to 40% of your Voluntary AD&D Insurance for your spouse or domestic partner and 10% of your Voluntary AD&D Insurance for each child
Spouse or Registered Domestic Partner Only	An amount equal to 50% of your Voluntary AD&D Insurance
Child(ren) Only	An amount equal to 15% of your Voluntary AD&D Insurance for each child
Maximum Spouse Voluntary AD&D Full Amount	$500,000
Maximum Child(ren) Voluntary AD&D Full Amount	$150,000

Eligibility, Enrollment, and Cost

You are eligible to participate in Voluntary AD&D insurance coverage the first of the month after you have completed six months of employment, and attained regular status, if you are a full-time or part-time union-represented employee of the Company. You are not eligible for this AD&D insurance coverage if you are a contractor, agency worker, hiring hall employee, or retired employee. Intermittent employees (except as noted) and other temporary employees who are not expected to become regular employees are also not eligible for coverage.

Enrollment

Your Voluntary AD&D Insurance coverage described in this section will go into effect on the first day of the month following completion of your enrollment. For example, if you were eligible to participate on February 1 as a union-represented employee, and you complete the enrollment process on February 15, you would be eligible for Voluntary AD&D Insurance, above the Company provided Basic AD&D, on March 1. If you enroll in Voluntary AD&D Insurance before you are actually eligible (e.g., before you attain regular status), your coverage will not take effect until the first of the month following the date on which you satisfy the eligibility requirements.

To enroll in Voluntary AD&D Insurance, log on to PG&E's Benefits Portal account via PG&E@Work for Me or mypgebenefits.com, or call the PG&E Benefits Service Center at **1-866-271-8144**.

If you do not complete the enrollment process when initially eligible, you will be assigned Basic AD&D Insurance coverage in the amount of $10,000. You may increase your level of coverage by enrolling for Voluntary AD&D Insurance coverage at any time during the year. Evidence of good health is not required for Voluntary AD&D Insurance coverage.

You must be actively at work on or after the effective date of your enrollment for coverage changes to take effect (e.g., if you are on sick leave or a leave of absence without pay, any changes to your Voluntary AD&D insurance coverage will not take effect until you return to work).

Actively at Work

"Actively at work" means you are performing all of the usual and customary duties that pertain to your work at the place where it is normally done, or where it is required to be done by your employer.

Cost of Coverage

The monthly cost for Voluntary AD&D coverage is based on a flat dollar rate (not an age-based rate) and on the level of coverage you elect. For coverage costs for yourself, spouse or registered domestic partner, and/or child(ren), refer to your personalized information which is available by logging on to PG&E's Benefits Portal.

How Your Benefit Is Paid

AD&D benefits are paid for covered losses if:

- You are injured in an accident that happens when your AD&D coverage is in effect, or
- Your covered dependent is injured in an accident that happens when AD&D coverage is in effect for that dependent; and
- The accident is the sole cause of injury, and that injury is the sole cause of the covered loss, and
- The covered loss occurs not more than 12 months after the date of the accident.

The amount of AD&D benefit payment is based on the level of coverage you elect and the type of loss that results from an accident, as follows:

Covered Loss	Benefit Amount
Life	Full Amount
Seat belt benefit	10% of the Full Amount up to $25,000
Air bag benefit	10% of the Full Amount up to $10,000

Covered Loss	Benefit Amount
A hand	50% of the Full Amount
A foot	50% of the Full Amount
An arm permanently severed at or above the elbow	75% of the Full Amount
A leg permanently severed at or above the knee	75% of the Full Amount
Sight of an eye	50% of the Full Amount
Any combination of a hand, a foot, and/or sight of an eye	100% of the Full Amount
Thumb and index finger on same hand	25% of the Full Amount
Speech and hearing in both ears	100% of the Full Amount
Speech	50% of the Full Amount
Hearing in both ears	50% of the Full Amount
Paralysis of both arms and legs (quadriplegia)	100% of the Full Amount
Paralysis of both legs (paraplegia)	50% of the Full Amount
Paralysis of one arm **and** one leg on the same side of the body (hemiplegia)	50% of the Full Amount
Paralysis of one arm **or** leg	25% of the Full Amount

For details on other covered losses, please refer to the MetLife Benefits Plan found on PG&E's Benefits Portal (accessible through PG&E@Work For Me or mypgebenefits.com).

Beneficiary Designation

Your beneficiary election for AD&D coverage is separate from the beneficiary election you make for your life insurance benefit. To establish, change or review your AD&D insurance beneficiary designations, log on to PG&E's Benefits Portal (accessible via PG&E@Work For Me or mypgebenefits.com), and update your Beneficiary information online. It is important that you always keep your beneficiary designations up to date. This is your responsibility. You may change your beneficiary designations at any time. If you enter your designations/changes into PG&E's Benefits Portal account, your updates are effective on the date on which you enter the information online.

Any beneficiary designation or change will not affect any payment MetLife Insurance Company makes or actions it takes before the notice of designation or change is received and processed.

No Beneficiary at Your Death

If no beneficiary should survive you, your benefit will be paid to the first survivor(s) in this order:

- your spouse (also includes registered domestic partner);
- your eligible children;
- your parents; or
- your eligible siblings.

If there is no surviving relative in any class, the benefit amount will be payable to your estate.

Travel Assistance and Identity Theft Solutions

As part of your Basic Accidental Death and Dismemberment (AD&D) Insurance coverage, you have access to Travel Assistance and Identity Theft Solutions through MetLife Insurance Company. The programs are offered at no cost to you.

Travel Assistance

Through a marketing arrangement with MetLife Insurance Company, AXA Assistance USA, Inc. (AXA) offers you and your dependents medical, travel, legal and financial assistance services, 24 hours a day, 365 days a year, worldwide.

You can access services when faced with an emergency while traveling internationally or domestically when more than 100 miles away from home. With one phone call, you and your dependents (whether traveling together or separately) will be connected to a global network of:

- Over 600,000 pre-qualified providers in more than 238 countries and jurisdictions.
- Air and ground ambulance services.
- Trained multilingual personnel who can advise and assist you quickly and professionally in a travel emergency.

Travel Assistance services include:

- **Medical referrals and appointments:** Your call to the Alarm Center enables you to be referred to English-speaking doctors, hospitals, dentists, or other specialists.
- **Hospital admission guarantee:** In the event that a hospital does not recognize your medical insurance, this travel assistance service will assist in guaranteeing hospital admission for you or your dependents by validating your health coverage and/or advancing funds.
- **Emergency evacuation:** Whenever adequate medical facilities are not available locally, this travel assistance service will provide whatever mode of transport, equipment and personnel necessary to evacuate you or your dependents to the nearest facility capable of providing proper care.
- **Critical care monitoring:** A team of doctors, nurses and other medically trained personnel will stay in regular communication with the attending physician and/or hospital to ensure you or your dependents are receiving proper care at all times.
- **Lost document and luggage assistance:** The service coordinates replacing lost documents and passports and provides assistance with locating lost luggage once a claim is filed.

You can view or download a copy of AXA's *Travel Assistance and ID Theft Solutions* brochure on PG&E's Benefits Portal (accessible through PG&E@Work For Me or mypgebenefits.com), or call AXA Assistance at **1-800-454-3679** (inside the United States). See *Contacts* for more information.

Identity Theft Solutions

Identity Theft Solutions offers tips on how to prevent identity theft, as well as personal guidance to individuals who are victims of this crime. The following services are available to you and your dependents, whether you are at home or on the road:

- **Education and tools:** Educational materials, prevention tool kits and resolution guides to provide information and support.
- **Personal guidance:** Case managers who can connect you to appropriate resolution contacts and provide direction on filing reports and complaints with various departments and agencies.
- **Ease and accessibility:** Access to services whether you are at home or traveling, 24 hours a day/seven days a week.

AXA Assistance can be reached at **1-800-454-3679** inside the United States. See *Contacts* for more information.

Hospital Confinement Benefit

As part of your Voluntary Accidental Death and Dismemberment (AD&D) Insurance coverage, you are eligible for a hospital confinement benefit, which pays an additional benefit if you or a dependent are confined in a hospital as a result of an accidental injury. Benefits begin on your fifth day of confinement and continue for up to 12 months of continuous confinement in the amount of the lesser of 1% of your full amount or $2,500 per month.

Additional AD&D Benefits

As part of your Voluntary Accidental Death and Dismemberment (Voluntary AD&D) Insurance coverage, you are eligible for the following benefits. For details, please refer to the MetLife Benefits Plan on PG&E's Benefits Portal (accessible through PG&E@Work For Me or mypgebenefits.com).

- Brain Damage Benefit
- Coma Benefit
- Child Care Benefit
- Child Education Benefit
- Spouse or Domestic Partner Education Benefit
- Common Carrier Benefit

Exclusions to AD&D Benefits

No benefits will be paid for any loss caused or contributed to by:

- physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- infection, other than infection occurring in an external accidental wound;
- suicide or attempted suicide;
- intentionally self-inflicted injury;
- service in the armed forces of any country or international authority, except the United States National Guard;
- any incident related to:
  - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
  - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  - parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
  - travel in an aircraft or device used:
    - for testing or experimental purposes;
    - by or for any military authority; or
    - for travel or designed for travel beyond the earth's atmosphere;
- committing or attempting to commit a felony;
- the voluntary intake or use by any means of:
  - any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a Physician; or
    - an "over the counter" drug, medication or sedative taken as directed;

- alcohol in combination with any drug, medication, or sedative; or
- poison, gas, or fumes; or

- war, whether declared or undeclared; or act of war, insurrection, rebellion or riot.

Exclusion for Intoxication

No benefits will be paid for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

What Happens…

If You Take a Leave of Absence

If you are on a Company-approved leave of absence, your Basic AD&D Insurance coverage will continue at no cost to you for the duration of your leave. Your Voluntary AD&D Insurance coverage will remain in effect, but you will be responsible for paying any premiums for the coverage. If you are receiving any type of PG&E pay while you are on leave, the premiums may be automatically deducted from the pay you receive.

If you'd like to redirect your VPDI pay, submit your request through:

- PG&E@Work For Me > About Me > My Pay or My Benefits > Benefits Redirect. While on leave, your access to the portal will remain enabled, even with your other PG&E network access disabled.

OR

- If you do not have computer access or are otherwise unable to log in to the portal, email **Benefits@pge.com** to request a Voluntary Plan Benefits Deduction Redirect Form.

If you are on an unpaid leave, your missed premiums will be suspended while you are on leave and then automatically deducted from your paycheck when you return to work. Note that these premiums will be taken from the first check.

If You Become Disabled

While you qualify for benefits from the Long-Term Disability Plan, your Basic AD&D Insurance coverage will continue at no cost to you. Your Voluntary AD&D Insurance coverage will remain in effect, but you will be responsible for paying the premiums for the coverage. Such premiums, if applicable, will be deducted automatically from any LTD payments you receive.

If You Retire

Only certain Key Employees who retire under the Company's Retirement Plan are eligible for postretirement AD&D Insurance. For more information, refer to the *Summary of Benefits Handbook for Retirees and Surviving Dependents* which is available online at mypgebenefits.com. You can also request the Handbook by calling the PG&E Benefits Service Center at **1-866-271-8144**.

When Coverage Ends

Your Basic and Voluntary AD&D insurance coverage ends:

- At the end of the month in which you retire;
- At the end of the month in which you cease paying required premiums;
- At the end of the month in which you are no longer considered eligible for benefits;

- At the end of the month in which your employment ends (other than retirement); or
- If the benefit(s) under the Group Life Insurance Plan is terminated by the Company or the carrier.

Claims and Appeals for Group Life and AD&D

MetLife Insurance Company is the Claims Administrator. To report a death or dismemberment and file a claim for life or AD&D benefits under the Group Life Insurance Plan, you or your beneficiary should contact the PG&E Benefits Service Center to request a claim form. In the event that you die, your family member or beneficiary should also contact **PG&E's HR Help Line at 415-973-4357** to notify the Company of your death. You or your beneficiary must follow the instructions on the claim form carefully and answer all questions completely to help expedite the processing of your claim. The completed claim form and any other required materials should be returned to the address on the form.

MetLife Insurance Company is solely responsible for determining life and AD&D benefit claims and appeals. If you have been denied a claim for benefits, you may submit an appeal to MetLife Insurance Company. The procedures governing initial claims and appeals are further described in this section.

Determinations relating to eligibility under the Group Life Insurance Plan or AD&D Plan are made by MetLife Insurance Company at the initial claim level and by the Employee Benefit Appeals Committee (EBAC) at the appeal level. If you have been denied benefits based on length of service, status, or membership in the Group Life Insurance Plan or AD&D Plans by MetLife Insurance Company, you may submit an appeal. The procedures governing length of service, status, or membership claims and appeals are further described in this section.

A claim for life insurance benefits, with proof as required by the insurance certificate, must be submitted as soon as is reasonably possible after the death of an insured A claim for any other benefits, with proof as required by the insurance certificate, must be submitted within 90 days of a date of a loss. If notice of claim or proof is not given within this time limit, the delay will not cause a claim to be denied or reduced if such notice and proof are given as soon as is reasonably possible, but, in no event, other than for lack of legal capacity, may proof be given later than one year after the date it is otherwise required. A legal action on a claim may only be brought during the period beginning 60 days after the date proof is filed and ending three years after the date such proof is required.

Claims Relating to a Benefit

If your initial claim relating to the payment or denial of a Group Life Insurance Plan benefit has been denied by MetLife Insurance Company Insurance Company, you will receive written notice of the denial within 90 days of receipt of the initial claim unless, due to special circumstances, an additional 90 days is required. Such notification will include:

- the specific reason(s) for the denial of the claim;
- a reference to the specific Plan provision(s) which apply to the denial;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures and the time limits applicable to such procedures; and
- a statement of your or your beneficiary's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

Appeals

If your initial claim relating to the payment or denial of a benefit has been denied by MetLife Insurance Company, you may submit a written appeal to MetLife Insurance Company. The appeal should be sent to Group Insurance Claims Review at the address of the MetLife Insurance Company office which processed your claim. Your appeal to MetLife Insurance Company must be received within 60 days of your receipt of notice that your claim has been denied by MetLife Insurance Company.

No special form or format is required in submitting a written appeal; you may submit written comments, documents, records and other information relating to your claim. You may also request, free of charge, access to, or copies of, all documents, records and other information relevant to your claim for benefits. The review of your appeal by MetLife Insurance Company will take into account all comments, documents, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered at the initial benefit determination.

If MetLife Insurance Company denies your appeal, you will receive a written response which will include:

- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) which apply to the denial;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;
- an explanation of any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- a statement of your right to bring an action under section 502(a) of ERISA.

You will receive a final ruling from MetLife Insurance Company within 60 days of MetLife Insurance Company's receipt of your appeal unless, due to special circumstances, MetLife Insurance Company requires additional time to respond, up to another 60 days.

Claims Relating to Eligibility

If you have a claim relating to your length of service, status, or membership in the Group Life Insurance Plan, you may submit it to the Employee Benefit Committee as Plan administrator. You will receive written notice of the denial within 90 days of receipt of the initial claim unless, due to special circumstances, an additional 90 days is required. Such notification will include:

- the specific reason(s) for the denial of the claim;
- a reference to the specific Plan provision(s) which apply to the denial;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures and the time limits applicable to such procedures; and
- a statement of your or your beneficiary's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

Appeals

If you are not satisfied with the Employee Benefit Committee's decision regarding your length of service, status or membership in the Plan, you may submit a written appeal to the Employee Benefit Appeals Committee (EBAC).

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

Your appeal to EBAC must be received within 90 days of your receipt of the denial of your claim by MetLife Insurance Company.

No special form or format is required in submitting a written appeal; you may submit written comments, documents, records and other information relating to your claim. You may also request, free of charge, access to, or copies of, all documents, records and other information relevant to your claim for benefits. The review of your appeal will take into account all comments, documents, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered at the initial benefit

determination. Please note, however, that it is the obligation of EBAC to administer the Plan fairly, consistently, and in accordance with the provisions of the Plan.

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

- the reason(s) for the denial of the claim;
- a reference to the Plan provision(s) which apply to the denial;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- an explanation of any voluntary appeal procedures and your right to obtain information about such procedures and a statement of your or your beneficiary's right to bring a civil action under section 502(a) of ERISA.

You will receive a final ruling from EBAC within 60 days of EBAC's receipt of your appeal unless, due to special circumstances, EBAC requires additional time to respond, up to another 60 days.

Helicopter Insurance

The Company provides helicopter insurance for employees who perform helicopter patrolling and other work while riding in a helicopter.

PG&E's helicopter insurance coverage for those who perform helicopter work are Zurich ($1,000,000 coverage) and W. R. Berkley Corporation ($1,000,000 coverage).

The policies provide accidental death and dismemberment insurance coverage to not only those who perform helicopter work, but also, to **anyone** who rides in PG&E's helicopters, as well as those who are in training to perform helicopter work–helping to ensure that everyone who conducts our important aerial work is financially protected should the unthinkable happen.

PG&E's helicopter insurance benefit provides automatic coverage of $2,000,000 accidental death and dismemberment (AD&D) coverage–up to an aggregate of $6,000,000 per incident–for any employee riding in the helicopter while performing job duties.

You can view more details on this benefit, as well as the insurance certificates, by visiting the Life and Accident Insurance page on mypgebenefits.com. For assistance in filing a claim for benefits under this benefit, please contact the PG&E Corporation Insurance Department at insurance@pge.com.

Your claim or appeal for benefits will be processed in accordance with the time frames set forth in "Claims and Appeals for Group Life and AD&D," and any claim or appeal denial will include the information set forth in that section.

Business Travel Insurance (BTI)

Business Travel Insurance (BTI) pays a benefit if your death or dismemberment is the result of a covered accident that occurs while you are traveling on Company business, subject to a few limitations. This benefit is paid in addition to any benefit payable from the Group Life Insurance Plan.

PG&E Corporation has entered into an insurance contract with ACE American Insurance Company (ACE) – a subsidiary of Chubb Ltd. – that provides for ACE to assume full responsibility and liability for the determination and payment of benefits. ACE insures the benefits described in this section of the handbook. ACE funds all benefits due under the Plan.

Eligibility

All active full-time employees who regularly work a minimum of 30 hours per week, and are traveling for work, are eligible for the BTI coverage equal to an amount up to three times your annual salary subject to a maximum benefit of $1,000,000. Your spouse, or registered domestic partner, is also eligible for this benefit if authorized by the Company to accompany you, at the Company's expense, on a business trip.

How Business Travel Accident Insurance Works

Your BTI coverage begins at the actual start of a Company business trip, whether you leave from your assigned work location, your home, or another location, whichever occurs last. BTI coverage ends when you return to your home or your assigned work location, whichever occurs first.

Travel involving normal commuting between your home and assigned work location is not considered Company business travel. Accidents that occur during normal commuting are not eligible for BTI coverage.

The BTI benefit is payable in addition to your Group Life Insurance Plan benefit if your death is the result of a covered accident that occurs while you are traveling on Company business.

Amount of Coverage

Your BTI benefit is equal to three times your annual salary, with a minimum of $125,000 and a maximum of $1,000,000. "Annual Salary" means your annual wage or salary that was in effect just prior to the date of the covered accident. Annual salary does not include amounts received as bonus, overtime pay, commissions, or other extra compensation.

If your spouse or registered domestic partner is authorized by the Company to accompany you on a business trip at the Company's expense, he or she is covered for $125,000, subject to limitations. Please refer to Limitations and Exclusions for further details.

Please note: The BTI eligibility rules for registered domestic partners are slightly different than those for the health care plans. Please contact the PG&E Corporation Insurance Department at insurance@pge.com for details about registered domestic partner coverage.

Your Beneficiary

Any benefit that is due as a result of a loss other than your death will be paid to you. Unless you specify otherwise, the beneficiary of the BTI death benefit is the same beneficiary designated for life insurance coverage. Please refer to "Eligibility, Enrollment, and Cost." You may designate a specific beneficiary for this BTI plan by requesting a Beneficiary Designation from the PG&E Corporation Insurance Department at insurance@pge.com.

Benefits are paid in a lump sum unless you (for losses other than your death), or your beneficiary (after your death), choose installment payments from one of the settlement options offered by ACE at the time payment is due.

BTI Benefits

Business Travel Insurance will pay a benefit if, within 365 days of a covered accident, your injuries result in one of the covered losses listed in the following chart. The benefit amount payable depends on the extent of your injuries.

"Loss" with respect to:

- hands or feet, means complete severance through or above the wrist or ankle joint;
- eyesight, means the total, permanent loss of sight of one eye. The loss of sight must be irrecoverable by natural, surgical or artificial means; or
- thumb and index finger, means the actual and complete severance through or above the metacarpophalangeal joints.

Examples of Covered Loss (See Description of Benefits in the Policy – page 11)	Benefit Amount
Life	100%
Multiple loss involving both hands, both feet, the sight in both eyes, or any combination of foot, hand and sight loss	100%
Loss of one hand, one foot, or sight in one eye	50%
Loss of a thumb and index finger of the same hand	25%

If you suffer more than one loss from an accident, ACE will only pay for the loss with the larger benefit.

If several employees are involved in a single accident, BTI will limit the total benefit paid to $20,000,000. If the total benefit that would otherwise be payable exceeds that total, the BTI benefit is prorated.

The above chart does not represent a complete listing of all covered loss examples. For further information, please contact the PG&E Corporation Insurance Department at insurance@pge.com.

Exposure and Disappearance

The Plan also covers loss resulting from unavoidable exposure to the elements and arising out of covered hazards.

If, within one year after the disappearance, stranding, sinking or wrecking of a vehicle in which you were an occupant, your body is not found, you will be presumed, subject to all other provisions and conditions of this insurance, to have suffered loss of life.

Limitations and Exclusions

The payment for all losses resulting from a single accident cannot be more than your individual coverage. For example, if an insured person receives a BTI benefit payment because of the accidental loss of a limb and later dies because of the same accident, the maximum benefit payable for both losses cannot be more than the total amount of that person's coverage.

Business Travel Insurance does not pay benefits for any loss or injury that is caused by or results from:

- intentionally self-inflicted injuries, suicide or attempted suicide;
- war or any acts of war, whether declared or not;

- a covered accident that occurs while on active duty service in the military, naval or air force of any country or international organization;
- sickness, disease, bodily or mental infirmity, bacterial or viral infection, or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
- piloting or serving as a crewmember in any aircraft (except as provided by the Policy);
- commission of, or attempt to commit, a felony.

The above list does not represent all limitations and exclusions that apply to this Plan. For further information, please contact the PG&E Corporation Insurance Department at insurance@pge.com.

Claims Information

Written (or authorized electronic or telephonic) notice of a claim must be provided to ACE within 90 days after any loss covered by the policy occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible.

Within 15 days of receiving notice of a claim, ACE will send claim forms to you for completion. Written (or authorized electronic or telephonic) proof of loss must be given to ACE within 90 days after the date of loss. If it cannot be provided within that time, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, should proof of loss be sent later than one year from the time proof is otherwise required.

For assistance in filing a claim for benefits under the Business Travel Insurance Plan, please contact the PG&E Corporation Insurance Department at insurance@pge.com.

Your claim or appeal for benefits will be processed in accordance with the time frames set forth in “Claims and Appeals for Group Life and AD&D,” and any claim or appeal denial will include the information set forth in that section.

Retirement Benefits

The Company offers four benefit plans that help you plan and save for your financial security after your retirement:

- The Pacific Gas and Electric Company Retirement Plan (the "Retirement Plan")
- The PG&E Corporation Retirement Savings Plan for Union-Represented Employees (the "Retirement Savings Plan," or "401(k) Plan")
- The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents
- The Pacific Gas and Electric Company Postretirement Life Insurance Plan

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company, PG&E Corporation, and other affiliated subsidiaries, collectively.

Note for the purpose of this Handbook:

"PG&E Pension Portal" refers to "PG&E PensionConnect." If you're within the PG&E network, you can log in to PensionConnect via PG&E@Work For Me > About Me > My Retirement > PG&E PensionConnect and you'll automatically be logged in to your account. From a personal device, you may log on by visiting myPensionConnect.com

The Retirement Plan and the Retirement Savings Plan have been designed to complement each other. Specifically:

- The Retirement Plan is a "defined benefit" plan, which means eligible participants receive a fixed pension benefit (with no cost-of-living adjustment) that is based on a defined formula reflecting credited service and pay. The Retirement Plan has two pension benefit formulas, based on when you were hired:
  - The Final Pay Pension formula if you were hired before 2013.—The Cash Balance Pension formula if you were hired on or after January 1, 2013—or if you elected the cash balance formula during a special, one-time election period in 2013.
- The Retirement Savings Plan, sometimes referred to as the 401(k) plan, offers eligible employees of PG&E Corporation, Pacific Gas and Electric Company and other designated subsidiaries a tax-advantaged way to save for retirement. It is a "defined contribution" plan, which means a participant's benefit varies with the amount of personal and Company contributions made to the plan as well as investment gains and losses on these contributions. The participation and contribution rules for PG&E's 401(k) plan are different depending on which pension formula you have:
  - Final Pay Pension Participants— a company match of $0.60 per dollar on your contributions of up to 3% or 6% of pay, depending on years of service
  - Cash Balance Pension Participants — a company match of $0.75 per dollar of your before-tax, Roth and/or after-tax contributions that do not exceed 8% of your base pay as long as you have completed one year of service

The Health Care Plan for Retirees and Surviving Dependents provides medical, mental health/substance use disorder treatment and prescription drug coverage for eligible retirees and their spouses/registered domestic partners and/or dependents. A detailed summary description of the Retiree Medical Savings Account (RMSA) you earn while you are working is included in this section. Additional information on RMSA and retiree medical coverage is available in the *Summary of Benefits Handbook for Retirees and Surviving Spouses* at mypgebenefits.com **> Resources > Summary of Benefits Handbooks**.

The Postretirement Life Insurance Plan provides eligible retirees with a specific amount of life insurance coverage. A summary description of the Postretirement Life Insurance coverage is included in this section. For more information about life insurance and administrative information, see *Life and Accident Insurance Plans*. Additional information is also available in the *Summary of Benefits Handbook for Retirees and Surviving Spouses* at mypgebenefits.com.

The Company also makes contributions toward your future Social Security retirement benefits. These contributions are in addition to the deductions for Social Security taxes taken out of your paycheck. Go to **ssa.gov** for more information about Social Security benefits.

You should plan carefully for your financial security after you retire. In addition to Social Security and the two retirement income plans available through the Company, your individual savings are a vital component in ensuring the lifestyle you desire when you retire. You may want to consult with a financial planner to develop an individual savings plan that is most appropriate for your future needs.

Retirement Plan at a Glance

The Pacific Gas and Electric Company Retirement Plan (the "Retirement Plan") provides eligible participants with a pension benefit, generally payable as a monthly annuity, that serves as a valuable part of your retirement income. It's important for you to understand how the Retirement Plan works and what kind of income you can expect from it so that you can begin planning for your retirement now. Your own savings, plus the benefits available to you from the Retirement Plan, the Retirement Savings Plan and Social Security, all contribute to your financial health in retirement.

Ready to Retire?

First, pick a date. Next, you'll need to:

1. Complete your pension paperwork 180–30 days before your benefit commencement date. Your completed paperwork must be received by the PG&E Pension Service Center by the expiration date listed in the Pension Election Kit.
2. Report your Intent to Retire to the PG&E Benefits Service Center 90-31 days before your retirement date.
3. Notify your supervisor in writing that you're resigning no later than five business days before your last day on employee payroll.

Employees can request a Pension Election Kit by:

1. Logging in to PG&E's Pension Portal at myPensionConnect:
   - From work: Visit PG&E@Work for Me > About Me > My Retirement > PensionConnect
   - From any computer or mobile device by visiting myPensionConnect.com
2. Calling the PG&E Pension Service Center at **1-800-700-0057**

If you have questions about your Pension Election Kit, you may use the Messaging Center in PG&E's Pension Portal to chat or send an email, or you may call the PG&E Pension Service Center at **1- 800-700-0057**.

See "Payment Options" for more information about making your retirement elections. Remember to notify your supervisor of your last day on employee payroll so your pension benefit can begin on time and your last paycheck will be processed in a timely manner. If you are divorced, you may need to obtain a Qualified Domestic Relations Order (QDRO) to divide your pension benefit with a former spouse. See "If You Divorced or Are Divorcing" or *Retirement Plan — Cash Balance Pension Benefit* for more information, including important details about submitting your retirement paperwork if you are divorced.

The Retirement Plan Benefit Formulas

When you retire, the Retirement Plan will pay you a pension benefit based on your eligible credited service and your pay. There are two retirement benefit formulas that may apply, based on your employment date and, in some cases, your benefit election. Both formulas provide a benefit that does not increase with inflation or otherwise once you begin receiving payments. Benefits under the Final Pay Pension are generally payable only as a monthly annuity; you will receive a fixed monthly amount for your lifetime, or for the combined lifetime of you and your spouse or named beneficiary. If you have a Cash Balance Pension account, you have the option to elect a single lump sum payout of your Cash Balance Pension account.

Final Pay Pension Formula

The Final Pay Pension formula applies to PG&E union-represented employees who were participants in the Retirement Plan prior to January 1, 2013. If you are rehired in 2013 or later, after a break of more than one year, you automatically participate in the Cash Balance Pension. Under the Final Pay Pension formula, your pension is determined by your final pay 30 days before you terminate employment and your years of credited service. For more information, see *Retirement Plan — Final Pay Pension Benefit*.

Employees participating in the Final Pay Pension formula who elected to participate in the Cash Balance Pension formula during the one-time pension choice period in 2013 stopped earning benefits under the Final Pay Pension formula when the Cash Balance Pension benefits became effective.

Cash Balance Pension Formula

The Cash Balance Pension formula applies to pension-eligible PG&E employees hired or rehired on or after January 1, 2013, and employees participating in the Final Pay Pension who elected a Cash Balance Pension during the one-time pension choice period offered in 2013. Under the Cash Balance Pension formula, your pension benefit consists of pay credits plus interest accumulated in your cash balance account over time.

For more information, see *Retirement Plan — Cash Balance Pension Benefit*.

Retirement Plan Highlights

- Participation in the Retirement Plan generally begins on your first day of employment with the Company, including any participating employer; there is no waiting period to begin earning a benefit. See *Retirement Plan — Cash Balance Pension Benefit* and *Retirement Plan — Final Pay Pension Benefit* for information regarding employees of PG&E Corporation and its designated subsidiaries.
- You have a vested right to your Retirement Plan benefits at the earlier of either three years of credited service with the Company (if you have a benefit under the Cash Balance Pension formula) or five years of credited service (if you have a benefit only under the Final Pay Pension), or at age 55. Once vested, you are eligible to receive a fixed benefit at retirement.
- No employee contributions are required.
- If you die while employed, a benefit may be payable to your spouse or a named beneficiary. If you want to name someone other than your spouse as the beneficiary, you and your spouse must complete the PG&E Retirement Plan Pre-Pension Commencement Designation of Beneficiary form. If you are not married, you must complete the designation form to name a beneficiary. You may also designate secondary/contingent beneficiaries by completing the designation form. You may obtain the form by logging into PG&E's Pension Portal.
- At retirement, you can elect monthly pension benefits for your lifetime, or for the combined lifetime of you and your spouse or named beneficiary. With the Cash Balance Pension benefit, you can also elect to receive your cash balance account amount in a single lump-sum payout.
- Once you have started receiving pension benefits, any elections you have made with respect to those benefits are irrevocable, except as noted under "Changing Your Election" or *Retirement Plan — Final Pay Pension Benefit* .
- Willis Towers Watson (WTW) is the third-party administrator to fulfill certain recordkeeping and administrative functions for the Retirement Plan.

See the respective plan descriptions for more details.

Retirement Plan — Final Pay Pension Benefit

The Retirement Plan is a “defined benefit” plan, which means eligible participants receive a fixed pension benefit that is based on a defined formula reflecting credited service and pay. The Retirement Plan has two pension benefit formulas, and this section describes the Final Pay Pension formula.

Benefits under the Final Pay Pension are generally payable only as a monthly annuity; you will receive a fixed monthly amount for your lifetime, or for the combined lifetime of you and your spouse or named beneficiary.

Employees participating in the Final Pay Pension who elected to participate in the Cash Balance Pension during the one-time pension choice period in 2013 stopped earning benefits under the Final Pay Pension when the Cash Balance Pension benefits became effective.

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Final Pay Pension Benefit at a Glance

This is the Summary Plan Description for benefits under the Pacific Gas and Electric Company Retirement Plan (the "Retirement Plan") Final Pay Pension formula for union-represented participants. Separate summary plan descriptions are provided to describe the benefits and eligibility for other Retirement Plan formulas.

- Under the Retirement Plan's Final Pay Pension formula, you earn a pension benefit based on your pay 30 days before your service ends and your years of credited service at retirement.
- Participation in the Retirement Plan for most employees (excluding hiring hall, probationary intermittent, temporary additional, outage employees, and certain other employee classifications) begins on your first day with the Company; there is no waiting period to begin earning a benefit.
- You're 100% vested in your Final Pay Pension after five years of eligible service with the Company or upon reaching age 55 while an employee of the Company.
- When you retire, you receive a fixed monthly benefit (an "annuity") for life.
- You may retire as early as age 55, but your monthly benefit will be reduced for early retirement, unless you have enough credited service to qualify for an unreduced pension.
- If you retire before age 65 and have at least 30 years of credited service, there is no reduction in your monthly pension benefit for early retirement.

Participating in the Final Pay Pension

You are eligible to participate in the Final Pay Pension if you were employed in an eligible classification prior to January 1, 2013, by Pacific Gas and Electric Company or any other company, association or credit union formally designated to participate in the Retirement Plan.

Additionally, if you elected to participate in the Cash Balance Pension during the one-time pension choice period offered in 2013, your Final Pay Pension was frozen as of December 31, 2013, and based solely on eligible pay and credited service at the time you ceased to earn additional benefits under this pension formula.

If you terminate employment and are rehired within 12 months and were a participant in the Final Pay Pension when you terminated employment, you will be treated as if you were employed by PG&E continuously. You will be reenrolled in the Final Pay Pension upon rehire.

If you terminate employment and are rehired on or after January 1, 2013 and your break in service from PG&E was for longer than 12 months, you will not participate in the Final Pay Pension upon rehire. Instead, you will participate in the Cash Balance Pension upon return.

Automatic Participation

Generally, employees hired prior to January 1, 2013, automatically began to participate in the Final Pay Pension on their first day of work.

You are not eligible to participate in the Final Pay Pension if you:

- are hired or rehired on or after January 1, 2013 (except as noted above);
- elected the Cash Balance Pension during the one-time pension choice period offered in 2013 (in which case your participation in the Final Pay Pension ended on December 31, 2013); or
- are treated by PG&E as an independent contractor, a consultant, or as an employee of an employment agency, even if you are later determined to be a common law employee of PG&E. This includes, but is not limited to, if you are a hiring hall, outage, probationary intermittent, or temporary additional under the IBEW Physical, IBEW Clerical and ESC Agreements, or you are excluded under any other agreement with a union.

Cost of the Plan

PG&E pays the full cost of your Final Pay Pension benefit. You are not required or permitted to make any contributions to the Plan.

How the Final Pay Pension Works

The Plan is designed to provide you with income when you retire from PG&E. Benefits under the Final Pay Pension are based on a formula that takes into account your pay 30 days before your service ends, and length of credited service with the Company. The actual amount you receive from the Retirement Plan will also vary depending on:

- your last day of work (which would be your last day of employment, even if you'll be on vacation)
- when you choose to commence your pension;
- your age when benefits begin; and
- any joint pension election you choose.

See "Your Pension Benefit" for additional information.

Estimates of Your Pension Benefit

You have a right to know the amount of your vested monthly benefit in the PG&E Retirement Plan. To assist you in understanding your pension benefit, you may use the Pension Estimator which is available through PG&E's Pension Portal located at myPensionConnect.com or through the PG&E@Work For Me intranet site (select My Retirement > PensionConnect). The Pension Estimator tool allows you to calculate your estimated monthly benefit based on information and assumptions that you enter.

You may also request a pension estimate by contacting the PG&E Pension Service Center at **1-800-700-0057**.

If you are planning to retire and start your pension, you must request a Pension Commencement Kit through PG&E's Pension Portal or call the PG&E Pension Service Center 180 to 30 days before your pension start date. Your completed paperwork must be received by the PG&E Pension Service Center before it expires. Your selected pension start date (also called benefit commencement date) is always the first of the month. It can generally be any date that is the first of the month after you end your PG&E employment. But note that payment may not actually begin on your benefit commencement date; it may take a couple of months before payment is made.

Employees can request a Pension Commencement Kit two ways:

1) Call the PG&E Pension Service Center at **1-800-700-0057**

2) Request through PG&E PensionConnect:

* From work: Visit PG&E@Work for Me > About Me > My Retirement > Pension Connect

* From home: Visit myPensionConnect.com

Pension estimates — whether performed by you or obtained through the PG&E Pension Service Center — are not binding and are subject to final review of payroll and employment data, as well as applicable Retirement Plan provisions. If a mistake is made, you will be paid the correct amount, even if that amount is less than the estimated amount.

Your Pension Benefit

The Retirement Plan uses the following formula to determine your Final Pay Pension benefit payable as of the first of the month following your 65th birthday:

Final Basic Weekly Pay Converted to Monthly Equivalent Pay *	×	1.5% × Credited Service Up to 25 Years	+	1.6% × Credited Service Over 25 Years	=	Monthly Pension Benefit

* Basic Weekly Pay is the hourly straight-time rate of pay as of 30 days before retirement/termination date multiplied by 2,080 hours, divided by 52 weeks. This Basic Weekly Pay is then rounded up to the nearest $10, multiplied by 52 weeks, divided by 12 months to determine Monthly Equivalent Pay.

The following example illustrates how the formula works. Let's assume you retire at age 65 with 30 years of credited service (for more information, see "**Error! Not a valid bookmark self-reference.**"). Let's also assume your basic weekly pay (defined below) and monthly equivalent pay are as follows:

- Basic Weekly Pay as of June 1, 2025 = $1,384.85 ($1,390.00 after rounding)
- Monthly Equivalent Pay = ($1,390.00 × 52 / 12) = $6,023.33

Monthly Equivalent Pay		Formula		Monthly Pension Benefit
$6,023.33	×	{(.015 × 25) + (.016 × 5)}	=	$2,740.62

In this example, your monthly pension benefit payable beginning at normal retirement (age 65) in the form of a single life annuity would be $2,740.62.

Basic Weekly Pay

Your "basic weekly pay" is equal to your straight-time hourly rate of pay, including any pension eligible premiums, for the basic work week as of the 30th day before your retirement/termination – not including any temporary upgrade pay, non-pension eligible premium pay, or any benefits of any kind (including, but not limited to, benefits from the 2022 Pacific Gas and Electric Company Voluntary Separation Plan) except as provided below – multiplied by 2,080 hours, divided by 52 weeks, then rounded up to the nearest $10.

This rate of pay is increased:

- by 2.75% for all clerical employees who received the 1988 lump-sum payment; or by 3.75% for clerical employees who received the 1988 and 1989 lump-sum payments; and
- by 4% for all former Pacific Gas Transmission (PGT) Company employees who received the 1991 PGT lump-sum payment; and
- to a minimum basic weekly rate of pay of $1,517.64 for IBEW Clerical employees, $1,661.82 for IBEW Physical and SEIU employees and $1,669.89 for ESC employees for calendar year 2021, as increased in subsequent years to reflect applicable general wage increases.

Special rules may apply to the determination of the appropriate basic weekly pay in the event that:

- you have at least 10 years of credited service and, due to a lack of work situation or physical disability, you are demoted, or you transfer or bid down before your retirement date;
- you are an inactive employee not on Long-Term Disability; or
- you retire from Long-Term Disability (LTD). If you retire from LTD, your average basic weekly pay is the highest of:
  - your Basic Weekly Pay for the classification you held on your last day worked prior to going on LTD, rounded up to the nearest ten dollars;
  - your LTD benefit payment;
  - the highest Basic Weekly Pay amount for Pension Band 1 of the Pension Band Table as of January 1, 2008 or $1,109.99, adjusted to reflect any general wage increase which has taken effect, rounded up to the nearest ten dollars: or
  - your Basic Weekly Pay on the date you return to work during the term of the Collective Bargaining Agreement in effect.

Additional Retirement Income

A special Plan feature also provides for an additional monthly pension for Retirement Plan participants who receive shift premiums, Sunday premiums and nuclear premiums. You must be at least age 55 when your employment ends to receive this benefit. This additional benefit is based on applying the Final Pay Pension formula to the average monthly straight-time premium received in the calendar year before retirement; however, if you elected the Cash Balance Pension during the one-time pension choice period offered in 2013, your additional retirement income will be determined as described above, for the period from January 1, 2013, through December 31, 2013.

Credited Service

Generally, as an eligible employee, you begin to earn service credit under the Retirement Plan beginning on your date of hire.

Regardless of any other Retirement Plan provision, you will not earn credited service under the Final Pay Pension on and after the date you cease to be eligible to participate in the Final Pay Pension.

Credited Service After 1975

As a participant and a full-time employee, you are given service credit for all periods of continuous employment with the Company and participating employers, including periods when:

- you are on an authorized leave of absence, including leaves of ESC-represented employees who are receiving:
  - Short-Term Disability (STD) Wage Continuation Benefits; or
  - Paid Family Leave (PFL) Wage Continuation Benefits.
- you remain employed and are entitled to receive any of the following:
  - Vacation or Holiday pay
  - Sick Leave for IBEW- and SEIU-represented employees – or – Incidental and/or Capped Sick Time for ESC-represented employees
  - Long-Term Disability (LTD) Plan benefits (does not apply to ESC-represented employees whose LTD effective date is on or after January 1, 2017, or to IBEW- or SEIU-represented employees whose LTD effective date is on or after January 1, 2018, as these employees do not earn credited service while receiving LTD benefits under Part IV of the LTD Plan)
  - Workers' Compensation or the Supplemental Benefits for Industrial Injury Plan; or;

- you are performing qualified military service (as long as your re-employment rights are protected by law) and return to work;
- you are laid off for lack of work for less than 12 continuous months, and are rehired within that 12- month period, if you had less than five years of credited service; or
- you are laid off for lack of work for less than 24 continuous months, and are rehired within that 24-month period, if you had five years or more of credited service.

Your credited service will end as of the earliest date on which you quit, retire or are discharged, the date of your death, or the first anniversary of the date you are absent from work for any reason not described above.

Credited Service Before 1976

Credited service prior to January 1, 1976, is calculated under the terms of the Retirement Plan in effect at that time. That is, if you joined the Retirement Plan when you first became eligible and were a regular employee who had completed one year of service, your credited service started with your employment date. If you did not join when you were first eligible and you did not take advantage of the one-time opportunity to "buy back" time in 1981, your credited service started with the date you joined the Retirement Plan.

Credited Service for Part-Time or Intermittent Employees

All credited service earned while you are a part-time or intermittent employee after December 31, 1990, will be prorated based on the ratio of actual straight-time hours worked in the calendar year to the full-time equivalent hours (2080). Hours worked does not include time you were receiving workers compensation or disability pay, or unpaid time. All service as a part-time or intermittent employee prior to January 1, 1991, will be considered full-time service.

A representative of the PG&E Pension Service Center can help you calculate your total service credits under these rules. For information about how breaks in service affect Retirement Plan benefits, see "Breaks in Service."

Credited Service Upon Re-Employment

If your employment with the Company ends and you are rehired after January 1, 2013, and you had a break in service of 12 months or more, you will participate in the Cash Balance Pension going forward. If your rehire date was before January 1, 2013, and in limited circumstances for rehires after January 1, 2013, you may be eligible to receive credit for your past service, provided you have not started to receive your pension benefit. Whether your past service is counted depends upon the following:

- the amount of credited service you had before you left the Company;
- how much time passed before you were rehired;
- when your termination and rehire took place; and
- if you were a member of the Retirement Plan before 1973, whether or not you withdrew your contributions to the Retirement Plan.

Generally, you do not have a break in service if you returned to work in a pension eligible position within 12 months after your service ended. In this case, your service was considered continuous and included the time you were not working for the Company. However, calculation of a break in service may be determined under different rules, depending on when the break occurred. See "Breaks in Service" for important information on credited service.

If you left the Company due to termination or retirement, began receiving your pension benefit, and were rehired before 2013, you began to accrue a new Final Pay Pension benefit from the date of rehire.

If you are rehired on or after January 1, 2013, and your break in service was longer than 12 months, you will begin to earn a new benefit under the Cash Balance Pension. If your break in service was longer than 12 months, your prior service will not be recognized for Final Pay Pension benefit purposes, but will be recognized for purposes of determining eligible pay credits under the Cash Balance Pension. See "How the Cash Balance Pension Works" for more information.

Vesting

You are 100% vested in the value of your Final Pay Pension benefit at the earliest of the following events:

- attaining age 55 while an employee of the Company; or
- completing five or more years of service; or
- completing three or more years of service if you are earning a benefit under the Cash Balance Pension formula.

For vesting purposes, service includes the period of time beginning with the first day you are employed with the Company and generally continues through the date when you terminate employment with the Company. If you terminate employment with the Company before vesting, you will lose your right to receive Retirement Plan benefits.

Breaks in Service

A break in service may affect your credited service for pension calculation purposes. A break in service occurs 12 months after your employment ends with PG&E in a position that was pension eligible. If you do not meet the following requirements, your service before the break is not included in calculating credited service for the Retirement Plan.

Breaks in Service Beginning:

On or After January 1, 1989

If you had five or more years of credited service when your employment ended, your credited service before the break will be counted. If you had less than five years of credited service, your credited service before the break will be canceled unless the break in service was shorter than five years.

On or After January 1, 1987, But Before January 1, 1989

If you had at least 10 years of credited service when your employment ended, your credited service before the break will be counted. If you had less than 10 years of credited service, your credited service before the break will not be counted if the period of break in service was equal to or exceeded the greater of:

- five years, or
- the period of credited service before your break in service.

On or After January 1, 1976, But Before January 1, 1987

If you had ten or more years of credited service when your employment ended, your credited service before the break will be counted. If you had less than ten years of credited service, your years of credited service before the break will be counted if the period of the break was less than your credited service at the time your employment ended.

In addition, if you were a participant before 1973, the restoration of your past service credit will depend on whether or not you withdrew your contributions to the Retirement Plan when you left the Company.

Before January 1, 1976

A “five-five-five” rule was in effect before January 1, 1976. Under this rule, upon either your death or retirement, your past service is counted if you:

- had at least five years of prior credited service,
- were rehired within five years of the date that your service ended, and
- worked at least five years after you were rehired.
- If you contributed to the Retirement Plan before 1973 and withdrew your contributions and interest when your employment terminated, any annuity or pension to which you are entitled will be reduced.

When Benefits Are Payable

Benefits are payable at the earliest of the following:

- When you elect to commence benefits at Early, Normal or Deferred Retirement:
  - Normal Retirement — refers to retirement at age 65. Your normal retirement date is the first day of the month after your 65th birthday and is the date you can receive an unreduced benefit from the Plan
  - Early Retirement — refers to retirement between the ages of 55 and 65. You can elect early retirement as of the first day of any month after your 55th birthday. There is no minimum service requirement to start your early retirement benefits. The shorter your service, the less you will receive from the Retirement Plan. See "Early Retirement Benefits" for details.
  - Deferred Retirement — refers to retirement after your normal retirement date. If you work past your normal retirement date, you will continue to accrue credited service toward your pension benefit from the Retirement Plan. See "Deferred Retirement Benefits" for details.
- If you die before you begin receiving pension payments, your surviving spouse or named beneficiary can generally start their Pre-Retirement Survivor's Pension benefit as of the later of the date of your death or the month that you would have attained age 55. See "If You Die Before You Commence Your Pension Benefit" for details.
- If you are a former employee with a vested benefit and reach the age of required minimum distributions for the Final Pay Pension benefit as required by federal law (age 73, or 72 for an employee who attained age 72 on or after January 1, 2020 and prior to January 1, 2023, or 70 ½ for an employee who attained age 70 ½ prior to January 1, 2020), you must start your pension benefit payments. See "If You Leave the Company with a Vested Benefit and Want to Start Your Pension" for details.
- If you are a former employee with a vested benefit subject to mandatory distribution. See "Mandatory Distributions" for details.

If you have both a Final Pay Pension and a Cash Balance Pension, your election to commence benefits under the Final Pay Pension is independent of your election to commence benefits under the Cash Balance Pension.

Starting Your Pension Payments

If you plan to start your pension benefit you must request a Pension Commencement Kit 180 – 30 days prior to your desired pension start date. To allow for calculation and final processing of your benefit, the earliest your first pension payment will be paid the first of the month following your pension start date and will include both the first and the second month benefit payments. If your completed Pension Commencement Kit is received after your pension start date, your first payment will be the first of the month, two months later. For example, if your pension start date is February 1, 2026 and your unexpired, properly completed Pension Commencement Kit was received February 5, 2026, your first payment will be April 1, 2026. Your first payment will include payments from your pension start date to the present. Please note that if you delay the start of payments from the Retirement Plan, the amount of your payments may increase. You should consider consulting a financial advisor before electing to start your pension payments.

If you are an active regular employee, you must resign and terminate your employment with PG&E prior to your pension start date. Your pension benefit will not start if you are working in a position that is pension eligible.

Early Retirement Benefits

You can elect early retirement on the first day of any month after your 55th birthday and before your normal retirement date. If you elect early retirement, your monthly pension benefit may be reduced to reflect the longer period of time you are likely to be receiving a pension. The amount of this reduction will depend on your years of credited service and your age when benefits begin, as shown in the following chart.

To begin your pension benefit, you must request a Pension Commencement Kit through myPensionConnect.com or call the PG&E Pension Service Center 180 to 30 days before your pension start date.

Reduction Percentage

Age	Reduction in Your Pension if Your Service Is...			
	Less Than 15 Years	15 to 24 Years	25 to 29 Years	30 Years or More
64	3%	—	—	—
63	6%	—	—	—
62	9%	—	—	—
61	12%	3%	3%	—
60	15%	6%	6%	—
59	18%	10%	9%	—
58	21%	14%	12%	—
57	24%	18%	15%	—
56	27%	22%	18%	—
55	30%	26%	21%	—

Note: Reduction factors are based on age in years and months prior to your normal retirement age (age 65). Although only ages as of your birth date are shown on this chart, the reduction factors change with each additional month of age after age 55.

For example, if an employee with less than 15 years of service retired at age 55, the reduction factor would be 30%. Each month of age past 55 will decrease the reduction factor. At age 55 years and four months, the reduction factor would be 29%, and so on. While reduction factors change for each month of age between birth dates, they do not change for additional months or years of credited service until you move into a new service band, as illustrated in the table. For example, if you are age 55 and four months with 16 years of service, the factors are the same as for someone at age 55 and four months with 23 years of service.

These reductions assume that your pension starts on the first day of the month after your birthday. If you leave the Company or retire early but delay receiving pension payments, the reduction percentage will depend on your age when pension benefits actually start. Therefore, your monthly pension benefit may increase with delayed commencement of your pension payments.

For example, if you retire at age 55 with 20 years of service:

Payment Commencement:	Single Life Annuity Payable on Your Normal Retirement Date (age 65)	Reduction Percentage (per chart)	Pension Benefit Amount as a Single Life Annuity
Age 55	$1,000 per month	26%	$740 per month $1,000-($1,000 × .26) = $740
Delayed to age 60	$1,000 per month	6%	$940 per month $1,000-($1,000 × .06) = $940
Delayed to age 62	$1,000 per month	0%	$1,000 per month
Delayed to age 65	$1,000 per month	0%	$1,000 per month

Deferred Retirement Benefits

If you continue working past your normal retirement age (age 65):

- You will continue to accrue service credit toward your pension benefit from the Retirement Plan if you decide to work beyond your normal retirement date, but you cannot begin receiving benefits as long as you are still working. You may elect to begin payment of your pension benefit when you actually retire. See "When Benefits Are Payable" for additional information.
- If you elect deferred retirement or to defer receiving your pension benefit after you have retired, your monthly pension benefit will be actuarially adjusted to reflect the shorter period of time you are likely to be receiving a pension. The amount of this increase will be offset by any additional pension benefit you earn under the Retirement Plan with each year of service after age 65 as long as you have not begun receiving payments.

See "Minimum Distributions" for additional information on legally required minimum distributions when you reach age 72.

Benefits If You Leave PG&E Before Age 55

If you leave PG&E before age 55 with at least five years of service (or at least three years of service if you also have a Cash Balance Pension), you are entitled to a vested benefit from the Retirement Plan. Service is defined in "Vesting." You may elect to begin receiving your Final Pay Pension on the first day of any month after reaching age 55. See "If You Leave the Company with a Vested Benefit and Want to Start Your Pension" for information about starting your benefit payments.

As a participant who terminated employment before age 55 with a vested benefit from the Retirement Plan, you are NOT considered a retiree of the Company and thus are ineligible for any other benefits that may be applicable to participants who ended employment on or after reaching age 55.

If you terminate employment before age 55 without a vested benefit, you will not be entitled to a benefit under the Final Pay Pension. If you are rehired by the Company after a break in service please refer to the section "Credited Service Upon Re-Employment" above for more information.

Minimum Distributions

Federal law imposes a minimum benefit amount that you must receive each year. This requirement typically applies if your first benefit payment begins after age 73 (72 for an employee who attained age 72 on or after January 1, 2020 and prior to January 1, 2023, 70 ½ for a participant who attained age 70 ½ prior to January 1, 2020). The purpose of the law is to make sure individuals entitled to receive a benefit actually receive it during their lifetime. If you remain employed with the Company past age 73 (72 for an employee who attained age 72 on or after January 1, 2020 and prior to January 1, 2023, 70 ½ for someone who attained age 70 ½ prior to January 1, 2020), you will not be subject to minimum distributions until your actual retirement date (subject to changes in tax law).

If you are subject to the minimum distribution requirements, the Plan Administrator will calculate the amount of your benefit that will satisfy the minimum distribution requirement for the Retirement Plan. If you participate in other plans, including the PG&E Corporation Retirement Savings Plan or any personal IRAs, the minimum distribution requirements for those plans or retirement accounts must be satisfied independently of the requirements for the Retirement Plan.

Mandatory Distributions

If you have a vested benefit from the Retirement Plan and the lump-sum present value of your pension benefit (including any benefit payable under the Cash Balance Pension) is less than $7,000 as of the date your employment ends, you must take distribution of the lump-sum value of your benefit. You may elect to receive a single cash payment shortly after your employment ends or elect to roll over the distribution to a tax-deferred

plan. If you do not make an election, distribution will be as follows, based on the lump-sum present value of your Retirement Plan benefit:

- Less than or equal to $1,000: You will automatically receive a single cash payment shortly after your employment ends.
- Greater than $1,000 but less than $7,000: The distribution will be paid as a direct rollover in your name to an individual retirement account (IRA) selected by the Plan Administrator.

The "present value" is the actuarial equivalent of your Final Pay Pension payable at your normal retirement date if you leave the Company before age 55, or the actuarial equivalent of your benefit at actual retirement date. The present value of your Cash Balance Pension, if applicable, is the vested account balance as of the date on which your employment ends. You will receive a written explanation about rollover options prior to receiving your distribution from the Retirement Plan.

Pre-Retirement Survivor's Pension

If you die before your Final Pay Pension payments begin, your surviving spouse or designated beneficiary is entitled to a benefit (a "Pre-Retirement Survivor's Pension"). For more information, see "If You Die Before You Commence Your Pension Benefit."

Payments to a Lost Participant or Beneficiary

It is your responsibility to keep your contact information on file with the Plan Administrator to ensure that the Plan Administrator can reach you regarding your pension benefits. In the event that you or your beneficiary(ies) cannot be located on the latest date upon which your Final Pay Pension benefits must start, your benefits will be forfeited. If you're later located, your benefits will be reinstated and adjusted if required by law.

Payment Options

When you retire, you choose how to receive your pension benefit. The Retirement Plan offers a number of annuity options, including some that continue payments to your spouse or other beneficiary in the event of your death. Your elections are made on your "Pension Benefit Election Form," and can be completed in one of two ways:

1. Online by logging in to PG&E Pension Connect through the PG&E@Work For Me (select My Retirement >PG&E Pension Connect) or by visiting myPensionConnect.com; or
2. By completing the Pension Election Form and mailing it back to the PG&E Pension Service Center such that it is received before the expiration date listed on the Pension Commencement Kit (which is generally 180 days from the date the kit was requested).

Payment option elections under the Final Pay Pension are independent of any payment option elections you make under the Cash Balance Pension.

To help you make the best decision for your needs, you can obtain an estimate of the pension amount you would receive each month under the various payment options available from the Retirement Plan by using the Pension Estimator Tool available through PG&E Pension Connect. The Pension Estimator Tool allows you to calculate your estimated monthly benefit based on information and assumptions that you enter. You may also request a pension estimate by contacting the PG&E Pension Service Center at **1-800-700-0057**.

In order to comply with ERISA requirements and to allow time for administrative processing, your completed Pension Benefit Election Form and supporting documents must be received by the PG&E Pension Service Center by the expiration date communicated in the cover letter. If your forms and supporting documentation are complete and returned on or prior to your benefit commencement date, you will receive payment on the 1st of the month following your benefit commencement date. If your completed paperwork is not received by the expiration date, which is generally 180 days from the date you requested it), your pension benefit will not commence and you will be required to request a new Pension Commencement Kit, with a benefit commencement date at least 30 days in the future. The Retirement Plan does not allow retroactive Pension Commencement Kit requests.

If you are:

- divorced or divorcing, see "If You Divorced or Are Divorcing" for more information, including important details about submitting your retirement paperwork if your former spouse may have a community interest in your pension benefit.
- unmarried at the time you begin receiving payments from the Retirement Plan, the default is a Single Life Pension with no provision for continuing payments to a survivor, unless you elect otherwise on the Pension Benefit Election Form.
- married at the time you begin receiving payments from the Retirement Plan, federal law requires that you be paid at least a 50% joint pension with your spouse as the joint pensioner (a "Marital Pension"). This form of benefit will, upon your death, continue making benefit payments to your spouse for your spouse's lifetime based on 50% of the payment amount during your life. If you elect continued payments of less than 50% for your spouse, or elect a joint pension with someone other than your spouse, both you and your spouse must sign the Pension Benefit Election Form, and your signatures must be witnessed by a Notary Public. For purposes of the Retirement Plan, you have a "spouse" if you are legally married under applicable law of a state or foreign jurisdiction, including a same-sex couple. However, in accordance with IRS guidance, a registered domestic partnership, civil union, or other similar formal relationship that is not denominated as a marriage under the law is not treated as being legally married for purposes of the Plan.

Single Life Pension

You may elect to receive your pension payable for your lifetime only and not provide any payments to a survivor. If you are married, your spouse must consent to this election in writing. If you choose to provide no continuing pension for your spouse, both you and your spouse must sign the Pension Benefit Election Form, and your signatures must be witnessed by a Notary Public.

Joint Pension

If you want to provide a continuing pension to someone in the event of your death, you may elect a "joint pension." You may designate anyone as your "joint pensioner." Your own pension benefit will be reduced so that up to 100% of this reduced amount can be continued to your joint pensioner in the event of your death. The amount your pension is reduced depends on your age and the age of your joint pensioner, as well as the percentage of your pension benefit that you elect to be continued to your joint pensioner.

Under a joint pension, your pension benefit will be calculated according to the Retirement Plan formula and then reduced by an actuarial factor based on your age and the age of your joint pensioner on your pension commencement date. This reduction is necessary because payments are guaranteed for two people and are likely to be paid for a longer period of time.

Here's an example:

Example of 50% Joint Pension

- Employee is age 65; joint pensioner is age 62
- Basic monthly pension is $1,655.40
- Employee elects a 50% joint pension

Because the joint pensioner is younger, the joint pensioner is expected to live longer. It's also likely that payments would be made over a longer period of time since pension benefits under this option will continue throughout the joint pensioner's lifetime and not end with the pensioner's death. So the monthly pension is reduced, in this case, using a factor of .947.

.947 × $1,655.40= $1,567.66

In other words, the reduced monthly pension is $1,567.66. In the event that the pensioner dies first, the joint pensioner would receive a lifetime continuing income of half this amount, or $783.83 per month.

$1,567.66 × 50% = $783.83

Joint pensions are available at 25%, 50% (the default Marital Pension for married employees), 75% and 100% of the pensioner's reduced monthly pension. You may elect any one of these joint pension options with any person you wish, subject to certain limits if your joint pensioner is more than 10 years younger than you are (for example, if you choose your child or grandchild as joint pensioner, the options higher than 50% may not be available for you to elect). If you are married and you elect continued payments of less than 50% for your spouse, or you elect a joint pension with someone other than your spouse, both you and your spouse must sign the Pension Benefit Election Form, and your signatures must be witnessed by a Notary Public.

Special Joint Pension ("Pop-Up")

You may also elect a "Special Joint Pension" which will allow your reduced monthly pension to increase or "pop up" to the full amount, as if you had never elected a joint pension, if your joint pensioner dies before you. However, your basic monthly pension benefit amount will be further reduced to reflect this additional benefit.

You may elect a Special Joint Pension that provides for a payment of 25%, 50%, 75% or 100% of your reduced benefit to your joint pensioner after your death. If you are married and you elect a Special Joint Pension with someone other than your spouse, or continued payments of 50% or less for your spouse, both you and your spouse must sign the Pension Benefit Election Form, and your signatures must be witnessed by a Notary Public.

Past Employee Contributions to the Retirement Plan

This provision applies only to employees who were employed before 1973. If you made contributions to the Retirement Plan and have a vested benefit, you have the option at your retirement or termination of employment to withdraw these contributions, plus interest, or leave them in the Retirement Plan.

- If you leave your contributions in the Retirement Plan, you will receive the full pension to which you are entitled.
- If you withdraw your contributions, the pension you receive will be reduced by the actuarial value of the contributions withdrawn.
- If you and your joint pensioner (if applicable) die before receiving total payments equal to or greater than your contributions plus interest, the difference between the amount of your contributions plus interest and the total payments received will be paid to your beneficiary (or the beneficiary of your joint pensioner, if applicable).

Tax Implications

Please note that although the Retirement Plan rules allow you to withdraw an amount equal to your contributions plus accrued interest, tax laws no longer allow you to consider the portion of the refund equal to your contributions as non-taxable. Be sure you are aware of the tax implications before you request a refund of contributions from the Retirement Plan; you may wish to consult a tax advisor before doing so.

Changing Your Election

Once you elect a payment option, you may change your election before your benefit commencement date. (Please note that this date may be before the first payment is actually made.) In order to do so, you must complete a new Pension Benefit Election Form and have it notarized. If you have submitted more than one Pension Benefit Election Form, your pension benefit will be based on the most recent correctly completed Pension Benefit Election Form received prior to your first pension payment.

Once you have submitted your completed paperwork and your benefit commencement date has passed, all of your elections are irrevocable. For instance, if you are receiving a pension benefit that continues a benefit to your spouse and your spouse dies before you do, your pension amount will not be increased unless you elected the special joint pension ("Pop-Up" pension) with your spouse. Your joint pension may not be transferred to another person, even if you remarry. If you elected a joint pension with your spouse as the beneficiary, your spouse at the time you completed the Pension Benefit Election Form is your beneficiary, even if you subsequently divorce or your spouse pre-deceases you.

Facility of Payment

If you are entitled to any payment under the Plan, and the Plan Administrator determines that you are physically or mentally incompetent to handle the payment, the Plan Administrator may cause all payments due to you to be made to a duly appointed guardian or conservator of your financial matters, in their capacity as guardian or conservator. If no guardian or conservator has been appointed to receive your payments, the Plan Administrator may make payments on your behalf to a custodial account set up on behalf of and for your benefit. Payments made on your behalf will completely discharge the Plan's responsibility for the amount of the payment.

No Guarantee of Employment

Participation in the Plan does not guarantee your right to employment with PG&E or any affiliates. Further, nothing set forth in this Summary Plan Description should be interpreted to give you or your beneficiary any legal or equitable rights against PG&E.

Military Service

Federal law provides rights to certain reemployed veterans for service credit, including for purposes of benefit accruals in certain situations, for periods of military service. Please contact the PG&E Pension Service Center at **1-800-700-0057** for more information.

Your Responsibility to Maintain a Current Address

You will receive periodic information regarding your Retirement Plan benefits. After your employment ends, you will receive periodic information about your vested benefit under the Retirement Plan. It is your responsibility to notify the Plan Administrator of any changes in your home address. To change your address, contact the PG&E Pension Service Center at **1-800-700-0057**.

If correspondence regarding your plan benefits is returned as undeliverable, the Plan Administrator will make efforts to locate you, including engaging the services of third-party address search companies. If the Plan Administrator is unable to locate you on the latest date upon which your Final Pay Pension must start, your benefit under the Plan will be forfeited andapplied to reasonable Plan administrative expenses. If a proper claim is later presented, your benefit will be reinstated and adjusted if required by law.

Borrowing, Pledging, and Assigning Interests in the Plan

No participant or beneficiary may borrow against, pledge, or assign — voluntarily or involuntarily, or by operation of law — any interest in the Retirement Plan or in any distribution to be made under the Retirement Plan. However, this does not prevent a spouse, former spouse, child, or other dependent of an employee to claim an interest in an employee's Retirement Plan benefits under a QDRO issued by a court (see "If You Divorced or Are Divorcing"). Generally, except as described above, no party, including creditors of PG&E, has or may create a lien on your benefit under the Retirement Plan.

What Happens…

If You Leave the Company with a Vested Benefit and Want to Start Your Pension

If you leave the Company with at least five years of service (or at least three years of service if you also earned a Cash Balance Pension) but before your 55th birthday, you have a vested pension benefit from the Retirement Plan. This means that you are guaranteed a future Final Pay Pension benefit from the Retirement Plan when you reach retirement age. You can elect to begin receiving your Final Pay Pension benefit at any time on or after the first day of the month following your 55th birthday. Different terms apply for the Cash Balance Pension; see "If You Leave the Company with a Vested Benefit and Want to Start Your Pension" for more information. If you elect

to start your pension payments before age 65, your *Final Pay Pension* benefit payable at age 65 will be reduced for early commencement, depending on your years of credited service and age as of your benefit commencement date, using the appropriate early retirement reduction factor. You may also elect a joint pension, as described in "Joint Pension."

If you leave the Company but delay receiving pension payments, the reduction percentage or actuarial adjustment percentage will depend on your age when pension benefits actually start. Therefore, your monthly pension benefit may increase if you choose to delay commencement of your pension payments (refer to the example under "Early Retirement Benefits"). However, benefit payments must begin no later than April 1 of the year after you reach age 73 (72 for an employee who attained age 72 on or after January 1, 2020 and prior to January 1, 2023, 70 ½ for an employee who attained age 70 ½ prior to January 1, 2020).

If you terminate employment before age 55 with a vested benefit, you must notify PG&E that you want to start your vested pension payments 180 to 30 days before the date on which you want to begin your pension benefit. Your completed paperwork must be received by the PG&E Pension Service Center before the Pension Commencement Kit expires. It is your responsibility to notify the PG&E Pension Service Center and request a Pension Commencement Kit at least 30 days prior to the date on which you want your vested pension benefits to become payable. The Plan does not allow retroactive payments.

See "When Benefits Are Payable" for important information on payment provisions.

It is your responsibility to keep your updated contact information on file with PG&E current to ensure that the Plan Administrator can reach you regarding your pension benefits. In the event that you or your beneficiary(ies) cannot be located on the latest date upon which your Final Pay Pension benefits must start, your benefits will be forfeited and applied to the Plan's reasonable administrative expenses . If you're later located, your benefits will be reinstated and adjusted if required by law.

If You Transfer to or from a Non-Union Position

Under the Retirement Plan, different benefit provisions apply to non-union-represented Management and Administrative & Technical (A&T) employees (covered under Part 1 of the Retirement Plan) than apply to union-represented employees (covered under Part 2 of the Retirement Plan). If you transfer to a non-union position or if you have transferred from a non-union position and you have accrued credited service under both Part 1 and Part 2 of the Plan, your pension benefit will be the larger of:

- the amount resulting from calculating *all* credited service under the benefit formula that applies for your current Management or Administrative & Technical (A&T) position, or
- the benefit amount for your credited service in your union classification under the Part 2 benefit formula added to the amount calculated under the Part 1 formula based on your non-union credited service. The amount for each portion of the benefit will be calculated using pay and all other benefit provisions and reduction factors applicable to the part of the Plan in which credited service was earned — including but not limited to factors for age, early retirement, joint pension, marital pension, and the election of an alternative spouse's pension.

Your retiree status will be associated with the last classification that you held before your employment ends and pension payments begin. For example, if you had union-represented service, then transferred to a management position and subsequently retired, you would be considered a management retiree.

If You Divorced or Are Divorcing

Under current California law, certain Company-provided employee benefits which you earn while married are community property and, thus, can be divided between you and your former spouse by court order in a divorce proceeding.

The Retirement Plan is a pension plan which is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. Under ERISA, if parties intend to divide Retirement Plan benefits in a divorce, they must prepare a specific court order, called a Qualified Domestic Relations Order ("QDRO").

A QDRO is a judgment, decree or order which relates to the provision of child support, alimony or marital property rights to an alternate payee (including a spouse, former spouse, child or other dependents). The QDRO creates or

recognizes the existence of an alternate payee's rights, and assigns to an alternate payee the right to receive all or a portion of the benefits payable to a participant under a plan.

If you have questions about the QDRO process, or would like a sample QDRO and the QDRO procedures, you can contact the QDRO Department at the PG&E Pension Service Center at -1-800-700-0057.

If you are ready to retire, and if your divorce decree and/or marital settlement agreement provides for a portion of your Plan benefit to be paid to your former spouse, before you can start your pension—you will need to provide a copy of your QDRO to the PG&E Pension Service Center.

You'll need to submit this documentation to the PG&E Pension Service Center regardless of how old the divorce or how short the marriage.

If you have both a Final Pay Pension and a Cash Balance Pension, and you have an existing court-filed QDRO relating to your Final Pay Pension, you and your former spouse may provide an amended court-filed QDRO that addresses both benefits. If you do not amend the existing QDRO, it is possible that the QDRO may apply to both of your benefits — your frozen Final Pay Pension and your Cash Balance pension — depending on the language in the QDRO and the determination date of the award, as interpreted by the Plan Administrator or its delegate.

If You Die Before You Commence Your Pension Benefit

The Retirement Plan may provide a pension benefit for your spouse or any designated beneficiary, if your death occurs before you commence your benefit. If you are married, your spouse is automatically your designated beneficiary. **You must complete a PG&E Retirement Plan Pre-Pension Commencement Designation of Beneficiary Form if you are not married or wish to name a beneficiary other than a spouse (if you are married). If you are married, your spouse must consent to your naming someone else, and your spouse's consent must be witnessed by a Notary Public. Any vested benefit you have under the PG&E Retirement Plan will be forfeited if:**

- You die before you start taking your pension benefit, and
- You're single or in a domestic partnership, and
- You haven't elected your pre-retirement pension beneficiary.

Designating A Beneficiary

You must complete a Pre-Pension Commencement Designation of Beneficiary Form if you wish to name a primary, secondary or non-spouse/contingent beneficiary for your Retirement Plan benefit in the event you die before you commence your benefit. If you also have a Cash Balance Pension, you must make a separate beneficiary election for your cash balance benefit. Contact the PG&E Pension Service Center at **1-800-700-0057** to request a form. Or you can visit PG&E's Pension Portal to update your beneficiaries online or download the appropriate form.

Contact the PG&E Pension Service Center for more information and the necessary forms. If eligible, the amount of your Pre-Retirement Survivor's Pension benefit will depend on your age, years of credited service and employment status at the time of your death. **If you are unmarried and die without a designated beneficiary, your Retirement Plan benefit will be forfeited.** For purposes of the Retirement Plan, you have a "spouse" if you are legally married under applicable law of a state or foreign jurisdiction, including a same-sex couple. However, in accordance with IRS guidance, a registered domestic partnership, civil union, or other similar formal relationship that is not denominated as a marriage under the law is not treated as being legally married for purposes of the Plan.

If you participate in the Plan's Cash Balance Pension benefit, you may designate a different non-spouse beneficiary for your Final Pay Pension than the non-spouse beneficiary you choose for your Cash Balance Pension benefit. Under the rules of the Retirement Plan, you may only elect one primary pre-retirement beneficiary and a trust cannot be named as a beneficiary.

Note for all survivor's benefits described below: If the present value of the pension benefit payable to your spouse or beneficiary is less than $7,000, the benefit will be paid as a single cash payment. See "Mandatory Distributions" for more information.

Pre-Retirement Survivor's Pension A

If you are an employee earning service under the Retirement Plan and:

- you are age 55 or older when your death occurs, or
- your age plus years of service total to 70 or more,

your survivor is entitled to a pension benefit equal to 50% of the basic pension you would have received had you elected retirement as of the first day of the month after your death. There is no reduction for early retirement. Pension benefits will be reduced by .05% for each month that your survivor is more than ten years younger than you. However, if your survivor is your spouse, the total reduction cannot result in a smaller pension benefit than what your spouse would have received under a 50% joint pension with applicable early retirement reductions.

The Pre-Retirement Survivor's Pension A is payable as soon as possible on or after your benefit commencement date after your death and continues for the life of your surviving spouse or beneficiary.

Pre-Retirement Survivor's Pension B

If you have at least five years of service when your death occurs, and if your survivor does not qualify for Survivor's Pension A, your survivor will be entitled to a pension benefit calculated under the formula for Survivor's Pension B, as follows:

- **For an Employee Who Dies Before Age 55 —** Your survivor will be entitled to a 50% joint pension. This benefit will be calculated as if you had terminated employment on the date of your death.

  Your survivor will begin receiving this benefit on the first day of the month after you would have reached age 55 unless he or she elects otherwise. If your survivor was not your spouse, his or her benefit must commence no later than December 31st of the calendar year after the calendar year of your death, even if that date occurs before the date that you would have reached age 55. The survivor's pension is actuarially adjusted to reflect your age and the survivor's age as of the benefit start date.

- **For a Former Employee Who Dies Before Age 55 —** Your survivor's benefit will be calculated as if you had survived until age 55 and elected a 50% joint pension. Your survivor will begin receiving this benefit on the first day of the month after you would have reached age 55 unless he or she elects otherwise. If your survivor was not your spouse, his or her benefit must commence no later than December 31st of the calendar year after the calendar year of your death, even if that date occurs before the date that you would have reached age 55. The survivor's pension is adjusted to reflect your age and the survivor's age as of the benefit start date.

- **For a Former Employee Who Dies at Age 55 or Older —** Provided you have not yet begun receiving pension payments from the Plan, your survivor's benefit will be equal to the 50% joint pension that would have been payable to your joint pensioner, had you made such an election as of the first of the month following your death. The benefit is effective the first day of the month following the month in which your death occurs unless the survivor elects otherwise. If your survivor was not your spouse, his or her benefit must commence no later than December 31st of the calendar year after the calendar year of your death.

If You Die Within 30 Days of Your Benefit Commencement Date

If your death occurs within 30 days of your benefit commencement date, you have submitted completed retirement paperwork to PG&E, and:

- **You are married and have elected a joint pension with your spouse**, your spouse will receive the greater of the joint pension you have elected or the Pre-Retirement Survivor's Pension, described above.
- **You are not married and have elected a joint pension with someone who is not on your Pre-Pension Commencement Designation, or you are married and have elected a joint pension with someone other than your spouse**, your joint pensioner will receive the greater of the joint pension or the amount of the Pre-Retirement Survivor's Pension.
- **You are single and you have elected a joint pension with your pre-retirement beneficiary**, your beneficiary will receive the greater of the joint pension you have elected or the Pre-Retirement Survivor's Pension.

If You Want to Begin Receiving Your Pension Benefit

If you're retiring, or you are a former employee and want to begin receiving your vested pension benefit, you must request a Pension Commencement Kit 180 to 30 days before the date on which you want to begin your pension benefit (see "Your Pension Benefit"). Your paperwork will include a "Pension Benefit Election Form." Keep in mind that some payment options require written spousal consent.

To help you make the best decision for your needs, you can obtain an estimate of the pension amount you would receive each month under the various payment options available from the Retirement Plan by using the Pension Estimator Tool available through the PG&E's Pension Portal. The Pension Estimator Tool allows you to calculate your estimated monthly benefit based on information and assumptions that you enter. You may also request a pension estimate by contacting the PG&E Pension Service Center at **1-800-700-0057**. These estimates are just that—estimates. The benefit amount you receive under the Retirement Plan will be determined based on the terms of the Retirement Plan, which is not bound by any benefit estimate you receive from any source.

Your completed Pension Benefit Election Form and supporting documents must be received by the PG&E Pension Service Center before your Pension Benefit Election Form expires, which is typically 180 days after the date you requested the election form. If your completed paperwork is not received before it expires, your pension benefit will not start and you will be required to request a new Pension Commencement Kit with a benefit commencement date at least 30 days in the future. The Retirement Plan does not allow retroactive Pension Commencement Kit requests. For example, if you requested your Pension Commencement Kit on November 15, 2025 with a requested pension benefit date of May 1, 2026, and your completed paperwork is received on June 1, 2026, your Pension Election Form expired before it was submitted. You must contact the PG&E Pension Service Center and request a new Pension Commencement Kit. After June 1, 2026, the earliest available benefit commencement date will be August 1. 2026 with your first payment from the PG&E Retirement Plan being issued no earlier than September 1, 2026.

Once you have submitted your completed paperwork, all of your elections are irrevocable, except your payment option as provided under "Changing Your Election."

If You Are Rehired

If you are a participant in the Final Pay Pension, terminate employment with PG&E, and are rehired on or after January 1, 2013 with a break in service longer than 12 months, you will automatically participate in the Cash Balance Pension. This is true even if you were an employee during the one-time pension choice period and did not elect to participate in the Cash Balance Pension.

If you're not vested when your employment ends, your service and benefit will be forfeited if the break in service exceeds five years. If the break in service is less than five years, your credited service and benefit will be restored, and you may be credited with pay and service for the time between your employment ending and your rehire (depending on the length and circumstances of the break). Your past service and service after rehire will be considered to determine vesting in your Retirement Plan benefits. If you are vested when your employment ends, your service will be restored regardless of the length of the break.

If You Also Have a Cash Balance Pension

There are two situations in which an employee may have both a benefit under the Final Pay Pension and a benefit under the Cash Balance Pension:

- If you elected the Cash Balance Pension during the one-time pension choice period in 2013, your total Retirement Plan benefit will have two components:
  - your accrued Final Pay Pension benefit as of December 31, 2013, payable as a monthly annuity; plus
  - your accrued Cash Balance Pension benefit from January 1, 2014, through the end of your PG&E employment (which can be paid to you as a lump sum or as an actuarially-equivalent annuity).
- If you are an employee who was rehired in 2013 or later with a break of service longer than 12 months who had earned a Final Pay Pension during your previous period of employment, your Retirement Plan benefit will have two components:

- your accrued Final Pay Pension benefit earned as of your last day of employment before your first rehire date which is on or after January 1, 2013 (payable as a monthly annuity); plus
- your accrued Cash Balance Pension benefit from your date of rehire through the end of your PG&E employment (which can be paid to you as a lump sum or as an actuarially-equivalent annuity).

For details about your Cash Balance Pension, see the *Retirement Plan — Cash Balance Pension Benefit*.

If Your Benefit Is Affected by IRS Limits

The Internal Revenue Code (IRC) and ERISA impose limitations on benefits provided under the PG&E Retirement Plan, both alone and in conjunction with other plans sponsored by PG&E. Generally, these limitations affect only the benefits of certain highly-compensated employees. The Plan Administrator will notify you if you are affected by these limits.

If the Retirement Plan becomes less than 60% funded, payment restrictions may apply and, subject to applicable IRC requirements, all Retirement Plan participants will automatically cease to earn any additional Retirement Plan benefits. The Plan Administrator will notify you if you are affected by these restrictions.

Claims and Appeals

To receive a benefit from the Retirement Plan, you generally must complete a Pension Benefit Election Form and provide any additional information needed to process your request and withhold taxes. If you believe a violation of ERISA or any other law has occurred, or you seek a remedy under any provision of ERISA or any other law, that relates in any way to the Retirement Plan, you will be considered a claimant who is subject the Retirement Plan's claims and appeals procedures and the requirement to exhaust these procedures.

Formal Claims Procedures

To make a formal claim, allege a violation of ERISA or any other law, or seek a remedy under any provision of ERISA or any other law, that relates in any way to the Retirement Plan, you must submit a formal claim to the Initial Claim Fiduciary by writing to:

Pacific Gas and Electric Company
Benefits Department
Retirement Plan Claims
300 Lakeside Drive
Oakland, CA 94612

No special form or format is required in submitting a written claim; you or your authorized representative may submit written comments, documents, records, and other information relating to your claim. You may also request, free of charge, access to, or copies of, all documents, records, and other information relevant to your claim. The Initial Claim Fiduciary's review of your claim will take into account all comments, documents, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered during any initial benefit determination by the Benefits Department. Please note, however, that it is the obligation of the Benefits Department, including the Initial Claims Fiduciary, to administer the Retirement Plan fairly, consistently, and in accordance with the provisions of the Retirement Plan.

You will receive written notice of the decision on your claim within 90 days of receipt of the initial claim unless, due to special circumstances, an additional 90 days is required. You will be notified in writing if a 90-day extension is necessary and the circumstances requiring the extension.

If the Initial Claims Fiduciary denies your claim, in whole or in part, you will be notified in writing. Such notification will set forth:

- the specific reason(s) for the denial of the claim;
- a reference to the Retirement Plan provisions which apply to the denial;
- a description of any additional material or information necessary for a participant or beneficiary to perfect the claim and an explanation of why such material or information is necessary;

- a description of the Retirement Plan's claims review procedures and the time limits applicable to such procedures; and
- a statement of the participant's or beneficiary's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review, and after exhausting your administrative remedies under the Retirement Plan.

If you are not satisfied with the Initial Claims Fiduciary's decision on your claim, whether in whole or in part, you may submit a written appeal for review (within 60 days of receiving notice of denial of your claim) to the Employee Benefit Appeals Committee ("EBAC"), the final adjudicator in the appeals process. You or your representative will have, upon request and free of charge, access to, and copies of, all documents, records and other information relevant to your claim. Your appeal must state the reasons for your appeal. You may include all documentation, records and any additional information to support your appeal. If you do not raise an issue on appeal or do not include a piece of evidence, the issue and evidence will not be considered by the EBAC on appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

You will receive a final ruling from the EBAC within 60 days of the EBAC's receipt of your appeal unless, due to special circumstances, the EBAC requires additional time to respond, up to another 60 days. You will be notified in writing if a 60-day extension is necessary and the circumstances for the extension.

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

- the specific reason(s) for denying your appeal;
- a reference to the specific Retirement Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
- a statement describing any voluntary appeals procedures offered by the Retirement Plan (if any) and your right to information about those procedures; and
- a statement of your right to bring a civil action under section 502(a) of ERISA.

A decision on your claim and appeal by the EBAC is final and binding on you and the Retirement Plan.

Exhaustion of Administrative Remedies

The claims review procedures described above are the exclusive claims administrative procedures provided under the Retirement Plan. You must exhaust these claims review procedures with respect to any claim, alleged violation of ERISA or any other law, or remedy sought under any provision of ERISA or any other law, that relates in any way to the Retirement Plan before taking action in another forum.

Legal Action

A claimant or any representative of a claimant may not bring action with respect to a claim, alleged violation of ERISA or any other law, or remedy sought under any provision of ERISA or any other law, that relates to the Retirement Plan in any way in any other forum after the earliest of the date that is:

- one year from the date of exhaustion of the Retirement Plan's claims review procedures described above;
- one-year from the latest date on which an appeal is permitted to be filed with the EBAC; or
- two years from the date the claimant knew or should have known that a claim existed.

Any such action must be filed in the Federal District Court for the Northern District of California.

The requirements for filing an action on a claim, alleged violation of ERISA or any other law, or remedy sought under ERISA or any other law, that relates to the Retirement Plan are in no way a waiver of the requirement to exhaust the claims review procedures under the Retirement Plan.

Rights under a Collective Bargaining Agreement

As a participant covered by a collective bargaining agreement between your union and the Company, you may use the grievance or adjustment procedure in your collective bargaining agreement to resolve any dispute concerning a question about your service with the Company, or your status or membership under the Plan.

The Pension Benefit Guaranty Corporation

Your pension benefits under the Retirement Plan are insured by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under a terminated plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- normal and early retirement benefits;
- disability benefits if you become disabled before the pension plan terminates; and
- certain benefits for your survivors.

The PBGC generally does not cover:

- benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates;
- some or all of the benefit increases and new benefits based on plan provisions that have been in place for fewer than five years at the time the plan terminates;
- benefits that are not vested because you have not worked long enough for the company;
- benefits for which you have not met all of the requirements at the time the plan terminates;
- certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and
- non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC, depending on how much money your plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington DC 20005-4026 or call 202-326-4000 or 1-800-400-7242. TTY/TDD users may call the **federal relay service at 1-800-877-8339** and ask to be connected to 1-800-400-7242. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at pbgc.gov.

Or contact:

Pacific Gas and Electric Company
Benefits Department
300 Lakeside Drive
Oakland, CA 94612

1-800-700-0057

Tax Considerations

All Plan distributions are considered taxable income and are subject to normal federal and (if applicable) state and/or local income taxes.

Annuity payments generally are subject to income tax withholding at ordinary income tax rates.

If you elect a lump-sum payment to be paid to you, the Company must withhold 20% federal tax from your distribution unless you elect a direct rollover. This withholding is sent to the IRS and is credited as part of your tax withholding for the year in which you receive your distribution.

If you're under age 59½ and don't roll over your lump-sum payment to an Individual Retirement Account (IRA) or other tax-qualified retirement plan, your distribution may be subject to a 10% federal income tax penalty in addition to the 20% withholding tax. State income tax penalties may also apply. However, the additional 10% IRS penalty does not apply if your payment is:

- paid to you because you leave the Company during or after the year in which you reach age 55;
- paid to you after you're permanently and totally disabled;
- paid to you as equal (or almost equal) payments over your life expectancy (or the combined life expectancies for yourself and your beneficiary);
- used to pay certain medical expenses; or
- paid to your beneficiary after your death.

Tax laws are complicated and subject to frequent change. You should consult a qualified tax advisor before making your distribution election.

Retirement Plan — Cash Balance Pension Benefit

The Retirement Plan is a "defined benefit" plan, which means eligible participants receive a fixed pension benefit that is based on a defined formula reflecting credited service and pay. The Retirement Plan has two pension benefit formulas, and this section describes the Cash Balance pension formula.

Benefits under the Cash Balance formula are based on your accumulated pay and interest credits, and are payable as a lump-sum payment or a monthly annuity payable for your lifetime, or for the combined lifetime of you and your spouse or named beneficiary.

Employees who elected to participate in the Cash Balance Pension formula during the one-time pension choice period in 2013 stopped earning benefits under the Final Pay Pension formula when the Cash Balance Pension benefits became effective.

Cash Balance Pension Benefits at a Glance

- Under the Pacific Gas and Electric Company Retirement Plan's Cash Balance Pension formula, you earn a pension benefit through a growing account.
- On the last day of each year, your individual cash balance account is credited with **pay credits** based on a point system of age plus service and your eligible pay during the year.
- At the end of each calendar quarter, your individual cash balance account is credited with **interest credits**, based on an average of the 30-year Treasury rates for the three months before the calendar quarter.
  - You're 100% vested in the value of your cash balance account after three years of service with the Company or upon reaching age 55 while an employee.
- When you leave PG&E, you can choose:
  - a lump-sum payout that is eligible for rollover into an IRA or other qualified employer plan; or
  - a monthly annuity for your life, or for the combined lifetime of you and your spouse or named beneficiary.

You can receive your fully vested account balance at any time after you leave PG&E.

Enhanced 401(k) Match

As a participant in the Cash Balance Pension, you are eligible for a higher 401(k) company match benefit under the PG&E Corporation Retirement Savings Plan than employees participating in the Final Pay Pension. As a Cash Balance Pension participant, you are eligible to receive a Company match of $0.75 per dollar on your contributions, up to 8% of your base pay, after you complete one year of service. See the summary of Retirement Savings Plan benefits for more information.

Participating in the Cash Balance Pension

You are eligible to participate in the Cash Balance Pension if you are:

- employed by Pacific Gas and Electric Company, PG&E Corporation or any other company formally designated to participate in the Retirement Plan (collectively, "PG&E" or "the Company"), and
- hired or rehired with a break of service of more than 12 months by PG&E on or after January 1, 2013, or
- an employee participating in the PG&E Retirement Plan on December 31, 2012 who elected to participate in the Cash Balance Pension during the one-time choice period offered in 2013.

Automatic Participation

Eligible employees hired or rehired on or after January 1, 2013, automatically participate in the Cash Balance Pension beginning on the first day of work.

If you were an existing eligible employee prior to January 1, 2013, and you elected to participate in the Cash Balance Pension during the one-time pension choice period offered in 2013, your participation in the Cash Balance Pension generally began on January 1, 2014, and your pension benefit under the Final Pay Pension formula was frozen as of December 31, 2013. Your frozen Final Pay Pension will be based on your eligible pay and credited service as of December 31, 2013, or the day before you begin to earn a benefit under the Cash Balance Pension, if later; it will not reflect changes in pay or additional credited service after that date. You are not eligible to participate in the Cash Balance Pension if you are:

- a hiring hall employee;
- an outage employee;
- a temporary additional (under the IBEW Physical Agreement); or
- a probationary intermittent employee under IBEW Physical, IBEW Clerical, and ESC Agreements; or
- excluded under the any other agreement with a union.

Cost of the Plan

PG&E pays the full cost of your Cash Balance Pension benefit. You are not required or permitted to make any contributions to the Plan.

How the Cash Balance Pension Works

When you first become eligible for the Retirement Plan's Cash Balance Pension benefit, a cash balance account is set up in your name. The amount credited to your account will grow over the course of your employment with PG&E through pay and interest credits. Please note that your cash balance account is a notional account that, once you are vested, is payable from the assets of the Retirement Plan trust when your employment ends. You can review your Cash Balance Pension benefits online by visiting PG&E's Pension Portal. If you leave PG&E for any reason, your benefit will be the vested balance in your cash balance account. You decide whether to receive that benefit as a monthly annuity for life or as a lump sum eligible for rollover into an IRA or another qualified plan, or to defer payment to a later date.

If you were hired before 2013 and have earned a benefit under the Final Pay Pension, your election to commence benefits under the Cash Balance Pension is independent of your election to commence benefits under the Final Pay Pension.

Pay Credits

Under the Cash Balance Pension formula, your cash balance account is credited on the last day of each year with pay credits. The amount of your annual pay credit is based on "points," which are a combination of your years of service and age. The table below shows the Plan's pay credit schedule:

Annual pay credits based on points (age + service):	
Fewer than 40 points	5% of pay
40-49 points	6% of pay
50-59 points	7% of pay
60-69 points	8% of pay
70-79 points	9% of pay
80 or more points	10% of pay

For the purpose of determining annual pay credits, attained age and years of service, with both age and years each expressed as whole numbers, are set as of the effective date pay credits are added to your account. For example, if you have worked for PG&E for 7 years, 9 months and are age 55½, you have 62 points (7 years of service plus 55 years of age). Service includes the period of time beginning with the first day you are employed with PG&E and generally continues through the date you terminate employment with PG&E. Service includes past service through 2013 also recognized under the Final Pay Pension formula. There is no credit for partial years and no proration for part-time service. If you leave PG&E before the end of the year, the pay credits earned for the partial year of service are credited to your cash balance account as of December 31st or the date benefit distributions begin, whichever is earlier. Note: The period during which you are eligible to receive benefits under the Long-Term Disability Plan IV, you will not receive service credit for purposes of points, but points will continue to accrue with respect to your age.

Covered Pay

Covered Pay includes:

- Straight time pay or salary for hours worked and for temporary upgrades;
- Shift, Sunday, and nuclear premiums at the straight-time rate;
- Vacation and paid time off (PTO) including amounts paid out at termination or retirement;
- Sick pay, including amounts paid out at termination or retirement due to a disability;
- Holiday pay (but excluding holiday pay upon termination);
- Inclement weather pay;
- Differential Pay for military training (unless such training qualifies for military leave of absence coverage);
- Pay during an approved leave of absence, including (for ESC-represented employees only) employer-paid Wage Continuation Benefit payments for Short-Term Disability (STD) or Paid Family Leave (PFL) leaves of absence; and
- Pay for other time off with permission.

Special Covered Pay Provisions

Special provisions apply when you are not receiving covered pay as defined above:

- Unpaid Leave of Absence. If you are a full-time employee immediately before an authorized leave of absence begins, covered pay will equal the rate of pay of your base classification in effect immediately before your leave of absence begins. Eligible leaves of absence include, but are not limited to, personal, medical, and

military leaves. Please see *Time Off and Leaves* for more information. If you are in a part-time position immediately before the leave of absence begins, your covered pay is based solely on eligible earnings paid to you while actively employed; you are not eligible for pay credits while on an unpaid leave of absence.

Long-Term Disability. While you are receiving Long-Term Disability Plan payments, your covered pay will be based on the greater of: (1) rate of pay of your base classification in effect on your last day worked, or (2) the amount being received under the Long-Term Disability Plan. Workers' Compensation. If you are receiving Workers' Compensation Temporary Compensation, your covered pay will equal the rate of pay of your base classification in effect immediately before your temporary disability benefits begin. (Covered Pay does not include:

- Pay or premiums for more than 40 hours a week other than premiums which are specifically negotiated to be Retirement Plan eligible;
- Overtime pay;
- Bonuses of any kind or commissions;
- One-time payments including incentives, recognition awards, severance payments, excess vacation payments, or sale of vacation;
- Non-taxable payments including Workers' Compensation, voluntary wage benefit or state disability plan benefits, reimbursements or other expense allowances;
- Fringe benefits, moving expenses, or welfare benefits (including, but not limited to, benefits from the 2022 Pacific Gas and Electric Company Voluntary Separation Plan).
- Per diem allowances, reimbursements and other special fees or allowances; or
- Otherwise, eligible covered pay while you are receiving pay credits based on a Special Covered Pay provision.

Covered Pay that may be considered by the Retirement Plan is also limited by requirements of the Internal Revenue Service. Visit the Retirement section of mypgebenefits.com to view the current year's Covered Pay amount that can be considered for determining your Retirement Plan benefits. This limit is indexed for inflation and may increase for future years.

Interest Credits

In addition to pay credits, your Cash Balance Pension Account is also credited with interest. On the last day of each calendar quarter, your cash balance account is credited with interest equal to your cash balance account as of the first day of the calendar quarter multiplied by a quarterly interest rate.

The quarterly interest rate is the average of the published annual rate for 30-year Treasury Security Rate for the first, second and third months immediately preceding the calendar quarter, divided by four. For example, the quarterly interest rate for the last quarter of 2025, or October through December 2025, equals the sum of the rates for October 2025 (4.64%), November 2025 (4.70%) and December 2025 (4.80%) divided by three to get the average annual rate. This result is rounded to four decimals and then divided by four to get the quarterly interest rate, which in this example would be 1.1775%. For any calendar quarter, the quarterly interest rate credit cannot be less than 0.4875%.

The published annual yields for 30-Year Treasury Security Rate can be found on the IRS website under Retirement Plans. (see irs.gov/Retirement-Plans/Weighted-Average-Interest-Rate-Table for the published rates). The annual yield for each month is based on the column for the 30-year Treasury Securities Rate (30-yr TSR)..

When you elect to begin benefit payments, you will receive a prorated quarterly interest credit for each month in the quarter before the date your cash balance benefit payments begin. For example, if you start payments on August 1, you will be credited with one-third of the quarterly interest that would normally be credited for the July – September quarter.

A Cash Balance Pension Account Example

Let's assume Sam is age 45 with 10 years of service and currently earns $90,000 a year. Annual pay increases by 3% each year, and interest credits are 3% per year (0.75% per quarter). Here's how Sam's account can grow over a five-year period.

Year	1	2	3	4	5
Beginning Balance	$0.00	$6,300.00	$12,980.13	$20,057.61	$28,533.77
Points (Age Plus Service)	55 (45 +10)	57 (46 + 11)	59 (47 + 12)	61 (48 + 13)	63 (49 + 14)
Annual Pay	$90,000	$92,700	$95,481	$98,345.43	$101,295.79
Q1 Interest Credits	$0.00	$47.25	$97.35	$150.43	$214.00
Q1 Ending Balance	$0.00	$6,347.25	$13,077.48	$20,208.04	$28,747.77
Q2 Interest Credits	$0.00	$47.60	$98.08	$151.56	$215.61
Q2 Ending Balance	$0.00	$6,394.85	$13,175.56	$20,359.60	$28,963.38
Q3 Interest Credits	$0.00	$47.96	$98.82	$152.70	$217.23
Q3 Ending Balance	$0.00	$6,442.81	$13,274.38	$20,512.30	$29,180.61
Q4 Interest Credits	$0.00	$48.32	$99.56	$153.84	$218.85
Pay Credit Rate	7%	7%	7%	8%	8%
Pay Credit	$6,300.00	$6,489.00	$6,683.67	$7,867.63	$8,103.66
Ending Balance	$6,300.00	$12,980.13	$20,057.61	$28,533.77	$37,503.12

In this example, the value of the cash balance account after five years is **$37,503.12**.

Minimum Benefit

If you are under a collective bargaining agreement that provides for a minimum benefit and you are vested (you completed three years of service or attained age 55 while an employee), you are entitled to a minimum benefit on your benefit commencement date equal to the greater of:

- your cash balance account; or
- $4,000 plus any interest credits from the date of your termination of employment. However, this amount will be reduced by the actuarially determined amount due or paid to you under this Cash Balance plan, under the Final Average Pay Pension plan, or under the Final Pay Pension plan.

Vesting

You are 100% vested in the value of your Cash Balance Pension at the earliest of:

- attaining age 55 while an employee of PG&E; or
- completing three or more years of service.

If you were previously participating in the Final Pay Pension formula and elected the Cash Balance Pension during the one-time choice period in 2013, you are vested in both your Cash Balance Pension benefit and your current Final Pay Pension benefit after completing a total of three years of service (or age 55, if earlier). Prior service earned while participating in the Final Pay Pension is counted toward this total.

If you terminate employment with the Company prior to age 55 and before earning three years of service, you will lose your right to receive a Cash Balance Pension benefit.

When Benefits Are Payable

You may review your Cash Balance Pension benefits online by logging in to PG&E's Pension Portal by visiting PG&E@Work For Me > About Me > My Retirement > myPension Connect or by visiting myPensionConnect.com. You may also request a Cash Balance Pension statement by calling the PG&E Pension Service Center at **1-800-700-0057**.

Once you are vested, you can receive your Cash Balance Pension benefit at any time after your employment with PG&E ends. Keep in mind that your account will continue to receive interest credits for as long as the account remains in the Plan. However, unless you continue employment with PG&E, you must begin to receive your benefit no later than April 1 of the year after the calendar year in which you reach age 73. See "Minimum Distributions" for important information that may apply to certain deferred retirements.

If you are seriously considering retirement in the near future, you must notify the PG&E Pension Service Center at least 30 days before your proposed benefit commencement date. You must submit your Pension Election and Authorization and supporting documentation to the PG&E Pension Service Center in order to receive your pension benefit. The address for the PG&E Pension Service Center is:

PG&E Pension Service Center
DEPT: PG&E
P.O. Box 981909
El Paso, TX 79998

The earliest your single lump-sum payout will be paid to you is on the first of the month following your benefit commencement date in order to allow for final processing and calculation of your Cash Balance Pension benefit, subject to certain restrictions. If you are receiving an annuity, the earliest your first pension payment will be paid the first of the month following your benefit commencement date and will include both the first and the second month benefit payments.

Estimates of your lump-sum payout or your pension annuity — whether performed by you online or obtained through the PG&E Pension Service Center — are not binding and are subject to final review of payroll and employment data, as well as applicable plan provisions. If a mistake is made, you will be paid the correct amount, even if that amount is less than the estimated amount.

When Your Employment Ends

If you terminate employment with PG&E and are vested in your Cash Balance Pension benefit, you'll be eligible to receive the full balance from your cash balance account in a lump sum or an actuarially-equivalent monthly benefit.

If you terminate employment at age 55 or older, your retirement status will be associated with the last classification you held before your employment ends and benefit payments begin. For example, if you had union-represented service, then transferred to a management position and subsequently retired, you would be considered a management retiree.

Mandatory Distributions

If you have a vested benefit from the Retirement Plan and the value of your Cash Balance Pension account (plus the present value of any benefits payable to you under the Final Pay Pension formula) is less than $7,000 as of the date you terminate employment with the Company, you may elect to receive a single cash payment shortly after your employment ends or elect to roll over the distribution to a tax-deferred plan. You will receive a written explanation about rollover options prior to receiving your distribution from the Retirement Plan.

Minimum Distributions

Federal law imposes a minimum benefit amount that you must receive each year. This requirement typically applies if your first benefit payment begins after age 73 (72 for an employee who attained age 72 on or after January 1, 2020 and prior to January 1, 2023, or 70 ½ for a participant who attained age 70 ½ prior to January 1, 2020). The purpose of the law is to make sure individuals entitled to receive a benefit actually receive it during their lifetime. If you remain employed with the Company past age 73 (72 for an employee who attained age 72 on or after January 1, 2020 and prior to January 1, 2023, or 70 ½ for a participant who attained age 70 ½ prior to January 1, 2020), you will not be subject to minimum distributions until your actual retirement date (subject to changes in tax law).

If you are subject to the minimum distribution requirements, the Plan Administrator will calculate the amount of your benefit that will satisfy the minimum distribution requirement for the Retirement Plan. If you participate in other plans, including the Retirement Savings Plan or any personal IRAs, the minimum distribution requirements for those plans or retirement accounts must be satisfied independently of the requirements for this Plan.

Death Benefits

If you die before your cash balance account is distributed, it will be paid to your beneficiary. If you are married, your spouse is your default beneficiary. If you are not married, and you do not designate a beneficiary, your account is forfeited. For more information, see "If You Die Before You Commence Your Pension Benefit."

Payment Options

You can receive your vested cash balance account in a one-time lump-sum payout or as a monthly-paid annuity payable for your lifetime at any time, beginning as early as the first of the month after your employment ends.

Note to participants with benefits earned before January 1, 2013: You must make a separate payment election for your Final Pay Pension benefit. You may elect to receive your cash balance account in the same annuity form and at the same time as your Final Pay Pension benefit. There may be situations, however, where your cash balance account can be distributed, but you must wait until a later date to receive your Final Pay Pension benefit.

Lump-Sum Payout

You may elect to receive a one-time distribution of your entire Cash Balance Pension account at retirement or termination of employment. The lump-sum payment is equal to the balance of your cash balance account after final pay and interest credits. There is no reduction for early retirement. The distribution is taxable and early withdrawal tax penalties may apply if you take a distribution before retirement age. If you roll over your account directly to an IRA or another qualified retirement plan, you will be taxed only when you actually receive the money.

If you are married and your benefit under the Retirement Plan is greater than $7,000, and you elect a lump-sum payout, your spouse must consent to this election in writing. Both you and your spouse must sign the Pension Election and Authorization, and your signatures must be witnessed by a Notary Public.

If your account balance is $7,000 or less, it will automatically be paid to you as a lump-sum payout. See "Mandatory Distributions" for more information.

Normal Annuity Payments

If your account balance is $7,000 or more, and you do not elect a lump-sum payout at termination of employment, the normal form of payment for your cash balance pension is a monthly-paid annuity.

The monthly-paid annuity is the actuarial equivalent of your Cash Balance Pension account. An actuarial equivalent is the fixed monthly benefit payable for your lifetime that is the equivalent value to your cash balance account. This actuarial equivalent is determined by multiplying your account balance dollar value by a factor based on your age (or the ages of you and your spouse/beneficiary), and interest and mortality rates set by the IRS in August of the prior year. For example, an annuity starting in February 2026 will use factors based on the 2026 IRS mortality and interest rates set in August 2025.

Below are the normal forms of payment based on your marital status at the time your benefit is scheduled to begin:

- **If you are unmarried at the time you begin receiving payments** from the Retirement Plan, you will automatically receive a Single Life Pension, with no provision for continuing payments to a survivor, unless you elect otherwise on the Pension Election and Authorization.
- **If you are married at the time you begin receiving payments** from the Retirement Plan, you will automatically receive a 50% joint pension with your spouse as the joint annuitant (a "Marital Pension"). This form of benefit will, upon your death, continue making benefit payments to your spouse for your spouse's lifetime based on 50% of the payment amount received during your life. If you elect continued payments of less than 50% for your spouse, or you elect a joint pension with someone other than your spouse, both you and your spouse must sign the Pension Election and Authorization, and your signatures must be witnessed by a Notary Public.

For purposes of the Retirement Plan, you have a "spouse" if you are legally married under applicable law of a state or foreign jurisdiction, including a same-sex couple. However, in accordance with IRS guidance, a registered domestic partnership, civil union, or other similar formal relationship that is not denominated as a marriage under the law is not treated as being legally married for purposes of the Plan.

Optional Forms of Annuity Payments

If you wish, you may waive the normal form of annuity payment and receive your benefit in one of the following optional forms of annuity payments.

Single Life Pension

- This is the normal annuity form for unmarried participants. If you are married, you may elect to receive your pension based on your own life expectancy only and not provide any payments to a survivor. Your spouse must consent to this election in writing. If you choose to provide no continuing pension for your spouse, both you and your spouse must sign the Pension Election and Authorization, and your signatures must be witnessed by a Notary Public.
- If you elect to receive your Cash Balance Pension benefit in the form of a Single Life Pension benefit, payments will stop at your death. A continuing Cash Balance pension will not be paid to your spouse or any other person after your death.

Joint Pension

These options are similar to the normal annuity form for married participants. If you want to provide a continuing pension to someone in the event of your death, you may elect a "joint pension." You may designate anyone as your "joint pensioner." Your own pension benefit will be reduced so that up to 100% of this reduced amount can be continued to your joint pensioner in the event of your death. The amount your pension is reduced depends on your age and the age of your joint pensioner, as well as the percentage of your pension benefit that you elect to be continued to your joint pensioner.

You may elect a joint pension that provides for a payment of 25%, 50%, 75%, or 100% of your reduced benefit to your joint pensioner after your death. If you are married, your spouse will need to consent to your election of a

joint pension with someone other than your spouse, or a joint pension with your spouse that only pays 25% of your benefit after your death.

In certain cases, IRS rules may limit the joint pension benefit payable to a non-spouse joint pensioner. The Plan Administrator will notify you if your desired joint pension election is affected by these rules.

Note, once your benefit commencement date has passed, all of your elections–your form of payment and your beneficiary–are irrevocable. (Note: your actual payment may be later than your benefit commencement date.) Your joint pension may not be transferred to another person, even if you remarry.

Special Joint Pension ("Pop-Up")

You may also elect a "Special Joint Pension" which will allow your reduced monthly pension to increase or "pop up" to the full amount, as if you had never elected a joint pension, if your joint pensioner dies before you. However, your basic monthly pension benefit amount will be further reduced to reflect this additional benefit.

You may elect a Special Joint Pension that provides for a payment of 25%, 50%, 75%, or 100% of your reduced benefit to your joint pensioner after your death. If you are married, your spouse will need to consent to your election of a joint pension with someone other than your spouse, or a Special Joint Pension with your spouse that only pays 25% or 50% of your benefit after your death. To make this election, both you and your spouse must sign the Pension Election and Authorization, and your signatures must be witnessed by a Notary Public.

Making Your Payment Election

Your elections are made in your Pension Commencement Kit. To help you make the best decision for your needs, the PG&E Pension Service Center will provide you with an estimate of the pension amounts you would receive under the various payment options available from the Plan.

In order to comply with ERISA requirements and to allow time for administrative processing, your completed Pension Commencement Kit and supporting documents must be returned to the PG&E Pension Service Center by the expiration date communicated in the cover letter. If your forms and supporting documentation are complete and returned on or prior to your Benefit Commencement Date, you will receive payment on the 1st of the month following your Benefit Commencement Date. Otherwise, forms received by the 1st of the month are paid on the 1st of the following month. If your completed paperwork is not received by the expiration date, you will be required to request a new Pension Commencement Kit. The Retirement Plan does not allow retroactive payments.

Changing Your Election

Once you elect a payment option, you may change your election before your benefit commencement date. In order to do so, you must complete a new Pension Commencement Kit and have it notarized. If you have submitted more than one Pension Election and Authorization, your pension benefit will be based on the most recently submitted correctly completed Pension Commencement Kit assuming your pension has not commenced.

Note, once your benefit commencement date has passed, all of your elections–your form of payment and your beneficiary–are irrevocable. (Note: your first payment may be after your benefit commencement date.) For instance, if you are receiving a pension benefit that continues a benefit to your spouse, and your spouse dies before you do, your pension amount will not be increased unless you elected the special joint pension with your spouse. ***Your joint pension may not be transferred to another person, even if you remarry.***

Different rules apply if you elect a joint pension and either you or your joint pensioner dies before your Retirement Plan payments begin. If your joint pensioner dies before your payments begin, the election you made on your Pension Election and Authorization will be ineffective, and you will receive a Single Life Pension benefit unless you elect otherwise. If you die before your payments begin, your surviving spouse or named beneficiary will receive the larger of the pre-retirement survivor pension (see "If You Die Before You Retire") or your elected joint pension.

Loss or Reduction of Benefits

There are certain circumstances under which your Cash Balance Pension benefits may be lost or reduced. These circumstances include the following:

- If you terminate employment with the Company prior to age 55 and before earning three years of service, you will lose your right to receive a Cash Balance Pension benefit.
- If you elect to receive your Cash Balance Pension benefit in the form of a Lump-Sum Payment, no further payments will be made to your spouse or any other person after the full value of our account balance has been paid to you.
- If you elect to receive your Cash Balance Pension benefit in the form of a Single Life Pension, Cash Balance Pension benefit payments will stop at your death. A continuing pension will not be paid to your spouse or any other person after your death.
- If you are not married and you die without a designated beneficiary, your Cash Balance Pension account will be forfeited.

Facility of Payment

If you are entitled to any payment under the Plan, and the Plan Administrator determines that you are physically or mentally incompetent and no guardian or conservator has been appointed to receive your payment, the Plan Administrator may make payments on your behalf to a third-party to be applied for and on behalf of and for your benefit. Payments made on your behalf will completely discharge the Plan's responsibility for the amount of the payment.

No Guarantee of Employment

Participation in the Plan does not guarantee your right to employment with PG&E or any affiliates. Further, nothing set forth in this Summary Plan Description should be interpreted to give you or your beneficiary any legal or equitable rights against PG&E or its affiliates.

Military Service

Federal law provides rights to certain reemployed veterans for service credit, including for purposes of benefit accruals in certain situations, for periods of military service. Please contact the PG&E Pension Service Center for more information.

Your Responsibility to Maintain a Current Address

After your employment ends, you will receive periodic information about your vested benefit under the Retirement Plan. As a retiree, it is your responsibility to notify the Plan Administrator of any changes in your home address. To change your address, contact the PG&E Pension Service Center at **1-800-700-0057**.

If correspondence regarding your plan benefits is returned as undeliverable, the Plan Administrator will make efforts to locate you, including engaging the services of third-party address search companies. If the Plan Administrator is unable to locate you on the latest date upon which your Cash Balance Pension payments must start, your benefit under the Plan will be forfeited and applied to pay reasonable Plan administrative expenses.. If a proper claim is later presented to the Plan Administrator, your benefit will be reinstated without any earnings or interest adjustment.

Borrowing, Pledging, and Assigning Interests in the Plan

No participant or beneficiary may borrow against, pledge, or assign — voluntarily or involuntarily, or by operation of law — any interest in the Retirement Plan or in any distribution to be made under the Retirement Plan.
Exception— A spouse, former spouse, child, or other dependent of an employee may claim an interest in an

employee's Retirement Plan benefits pursuant to a QDRO issued by a court (see "If You Divorced or Are Divorcing"). Generally, except as described above, no party, including creditors of the PG&E, has or may create a lien on your benefit under the Retirement Plan.

What Happens…

If You Leave the Company

As long as you are fully vested in your benefit under the Plan, you can elect to receive the full balance of your cash balance account paid to you in a single lump-sum payment or to receive an actuarially-equivalent monthly lifetime benefit. A lump-sum payment or the monthly benefit amount would be subject to income tax. Any withdrawals before age 59½ could incur federal or state early withdrawal tax penalties, unless you roll your account balance to an IRA or another qualified retirement plan.

If You Are Divorced or Divorcing

Under current California law, certain Company-provided employee benefits which you earn while married are community property and, thus, can be divided between you and your former spouse by court order in a divorce proceeding.

The Retirement Plan is a pension plan which is governed by the Employee Retirement Income Security Act of 1974 (ERISA). Under ERISA, if parties intend to divide Retirement Plan benefits in a divorce, they must prepare a specific court order, called a Qualified Domestic Relations Order (QDRO).

A QDRO is a judgment, decree or order which relates to the provision of child support, alimony or marital property rights to an alternate payee (including a spouse, former spouse, child or other dependents). The QDRO creates or recognizes the existence of an alternate payee's rights and assigns to an alternate payee the right to receive all or a portion of the benefits payable to a participant under a plan.

If you have questions about the QDRO process, or for a sample QDRO and QDRO procedures, you can call the QDRO Department at the PG&E Pension Service Center at **1-800-700-0057**.

If you are ready to retire, and if your divorce decree and/or marital settlement agreement provides for a portion of your Plan benefit to be paid to your former spouse, before you can start your pension, you will need to provide a copy of your QDRO to the PG&E Pension Service Center.

You'll need to submit this documentation to the PG&E Pension Service Center regardless of how old the divorce or how short the marriage.

If you have both a Final Pay Pension and a Cash Balance Pension, and you have an existing court-filed QDRO relating to your Final Pay Pension, you and your former spouse may provide an amended court-filed QDRO that addresses both benefits. If you do not amend the existing QDRO, it is possible that the QDRO may apply to both of your benefits – your frozen Final Pay Pension and your Cash Balance pension – depending on the language in the QDRO and the determination date of the award, as interpreted by the Plan Administrator or its delegate.

If You Die Before You Retire

The Retirement Plan may provide a pension benefit for your spouse or a designated beneficiary if your death occurs before you receive your cash balance account. If you are married, your spouse is automatically your designated beneficiary. **You must complete a Pre-Pension Commencement Designation of Beneficiary Form if you are not married or wish to name a beneficiary other than a spouse for your Retirement Plan. If you are married, your spouse must consent to your naming someone else, and your spouse's consent must be witnessed by a Notary Public. Any vested benefit you have under the PG&E Retirement Plan will be forfeited if:**

- You die before commencing your benefit, and
- You're single or in a domestic partnership, and
- You haven't elected your pre-retirement pension beneficiary.

Designating A Beneficiary

You must complete a Pre-Pension Commencement Designation of Beneficiary Form if you wish to name a primary, secondary or non-spouse/contingent beneficiary for your Retirement Plan benefit in the event you die before you retire. If you also have a Cash Balance Pension, you must make a separate beneficiary election for your cash balance benefit. Contact the PG&E Pension Service Center at **1-800-700-0057** to request a form. Or you can visit the online PG&E's Pension Portal to update your beneficiaries online or download the appropriate form.

Contact the PG&E Pension Service Center or log in to PG&E's Pension Portal by visiting PG&E@Work For Me > My Retirement > PG&E Pension Connect or visiting myPensionConnect.com for more information and the necessary forms. For purposes of the Retirement Plan, you have a "spouse" if you are married under applicable law of a state or foreign jurisdiction, including a same-sex couple. However, in accordance with IRS guidance, a registered domestic partnership, civil union, or other similar formal relationship that is not denominated as a marriage under the law is not treated as being legally married for purposes of the Plan.

Forms to designate a pre-retirement beneficiary are available by request by contacting the PG&E Pension Service Center. If you're married, that notice describes your right to designate a non-spouse beneficiary to receive a pre-retirement survivor's pension — and your spouse's right to consent to such election. Contact the PG&E Pension Service Center for more information and the necessary Pre-Pension Commencement Designation of Beneficiary Forms.

If you are married:

- Your spouse is your designated beneficiary. If you die before receiving your benefits, your spouse will receive your vested cash balance account in a single life pension annuity. Instead of the single life annuity, your surviving spouse may elect to receive the amount of your vested account in a single lump-sum payment.
- If you have named someone other than your spouse as beneficiary, your beneficiary will receive your vested cash balance account in a single lump-sum payment. Instead of the lump sum, your beneficiary may elect to receive the amount of your vested cash balance account in a single life pension annuity.

If you are not married:

- You must designate a beneficiary to have your cash balance account paid as a survivor benefit. If you are not married and do not designate a beneficiary, your cash balance account will be forfeited upon your death.
- If you die before commencing your benefit, your beneficiary will receive your vested cash balance account in a single lump-sum payment. Instead of receiving the lump sum, your beneficiary may elect to receive the amount of your vested cash balance account in a single life pension annuity.

If the total Retirement Plan benefit payable on your death is less than $7,000 as of the date of death, the mandatory distribution rules will apply to benefits payable to the spouse or beneficiary. See "Mandatory Distributions" for more information.

Payment of the survivor benefit will be made as of the first of the month following your death. Your spouse or beneficiary may elect to defer payment until a later date unless your account is subject to mandatory distribution. A beneficiary election to receive payment in the form of a pension annuity must be made no later than December 31 of the year following your death.

If you die *after* beginning monthly payments of your benefit, payments will continue to your spouse or designated beneficiary only if you elected an annuity form of payment that includes a survivor benefit.

Note to participants employed before January 1, 2013: If you are vested and die before receiving a monthly benefit under the Final Pay Pension formula, your spouse or designated beneficiary may be eligible to receive a monthly survivor benefit from that benefit formula. See "If You Die Before You Retire" for more details about the pre-retirement survivor annuity. You may elect a different beneficiary for your Cash Balance Pension than the person you choose for your Final Pay Pension benefit.

If You Die Within 30 Days of Your Benefit Commencement Date

If your death occurs within 30 days of your benefit commencement date, special rules apply:

- If you are married and have submitted completed retirement paperwork to PG&E electing a joint pension with your spouse, your spouse will receive the greater of the joint pension you have elected or the Pre-Retirement Survivor's Pension described above.
- If you are not married and have elected a joint pension with someone who is not on your Pre-Penson Commencement Designation of Beneficiary Form, or if you are married and have elected a joint pension with someone other than your spouse, your joint pensioner will receive the greater of the joint pension that you elected or the amount of the Pre-Retirement Survivor's Pension.
- If you are single and you have elected a joint pension with your pre-retirement beneficiary, your beneficiary will receive the greater of the joint pension you have elected or the Pre-Retirement Survivor's Pension.

If You Are Rehired on or After January 1, 2013

If you leave PG&E while participating in the cash balance formula and are later re-hired, the impact on your cash balance account will depend on your vesting status and on whether you received a Cash Balance Pension benefit upon leaving PG&E:

If You Were Vested in Your Cash Balance Pension at Termination	
And You Received Your Cash Balance Pension Benefit	▪ **Previous Lump-Sum Payout:** If you received a lump-sum payout of your cash balance account, when you are rehired, your starting cash balance account at rehire will equal $0. Going forward, you'll receive pay credits and interest credits to your account. Prior service will be considered in determining points used to calculate pay credits. ▪ **Previous Monthly Annuity Payments:** If you are receiving monthly annuity payments from your previous cash balance account, these payments will continue. A new cash balance account will be established for you with an initial balance of $0. Going forward, you'll receive pay credits and interest credits to your account. Prior service will be considered in determining points used to calculate pay credits.
And You Did Not Receive a Cash Balance Pension Benefit	▪ If you didn't receive a distribution from your previous cash balance account, then when you are rehired, your account balance will equal the balance at your termination date plus interest credits earned until your date of rehire. Going forward, you'll receive pay credits and interest credits to your account. Prior service will be considered in determining points used to calculate pay credits.

If You Were Not Vested in Your Cash Balance Pension at Termination	
And Your Break-in-Service Was…	▪ **Less Than Five Years Prior to Rehire:** If you have a break-in-service that is less than five years, then when you are rehired, your account balance as of your termination date will be restored and interest credits for the period of the break will be applied. Going forward, you'll receive pay credits and interest credits to your account. Prior service will be considered in determining points used to calculate pay credits. ▪ **Five Years or More Prior to Rehire**: If your break-in-service equals or exceeds five years, then when you are rehired, your cash balance account will equal $0. Going forward, you'll receive pay credits and interest credits to your account. Prior service will be considered in determining points used to calculate pay credits.

If You Were Vested in a at Termination	
And You Started Receiving Your Final Pay Pension	▪ **The annuity you are receiving will continue being paid during re-employment; there is no suspension of benefit.** You will start earning a new Cash Balance Pension benefit upon re-employment. However, points used to determine cash balance pay credits will recognize prior service for which a Final Pay Pension is being paid.
And You Have Not Started Receiving Your Final Pay Pension Benefit	▪ **12 months or less:** Your service is considered continuous and you continue earning benefits under the Final Pay Pension. Your credited service before the break will be counted. ▪ **More than 12 months:** You will automatically begin earning a Cash Balance Pension. Points used to determine pay credits will recognize prior service. You can elect to start receiving your vested Final Pay Pension benefit payments at any time after your employment ends and you are age 55 or older.

If You Were Not Vested in a at Termination	
And Your Break in Service Was:	▪ **12 months or Less:** Your benefit earned under the Final Pay Pension up to your termination date will be restored and you continue earning benefits under the Final Pay Pension. ▪ **Less than Five Years:** Your benefit earned under the Final Pay Pension up to your termination date will be restored. Prior service will be recognized for cash balance pay credits and vesting in both the Final Pay Pension and Cash Balance Pension benefit. ▪ **More than Five Years:** Your benefit earned under the Final Pay Pension up to your termination date will not be restored. However, your prior service will be recognized for determining cash balance pay credits going forward.

If You Also Have a Benefit Under the Final Pay Pension Formula

There are two situations in which an employee may have both a benefit under the Cash Balance Pension and a benefit under the Final Pay Pension.

- If you elected the Cash Balance Pension during the one-time pension choice period in 2013, your Retirement Plan benefits will have two components:
  - Your accrued **Final Pay Pension benefit** as of December 31, 2013, payable as a monthly annuity; plus
  - Your accrued **Cash Balance Pension benefit** from January 1, 2014, through the end of your PG&E employment (which can be paid to you as a lump sum or as an actuarially-equivalent annuity).

- If you are an employee who was rehired in 2013 or later who had earned a Final Pay Pension during your previous period of employment, your Retirement Plan benefits will have two components:
  - Your accrued **Final Pay Pension benefit** earned as of your last day of employment before your first rehire date which is on or after January 1, 2013 (payable as a monthly annuity) and your break of service was longer than 12 months; plus
  - Your accrued **Cash Balance Pension benefit** from your date of re-hire, through the end of your PG&E employment (which can be paid to you as a lump sum or as an actuarially equivalent annuity).

All credited service earned under the Final Pay Pension will be recognized in determining pay credits under the Cash Balance Pension. For details about your Final Pay Pension, see *Retirement Plan — Final Pay Pension Benefit* .

If you are earning a benefit under the Cash Balance Pension formula, you are also eligible for a higher Company match on your 401(k) contributions. See *Retirement Savings Plan* for more information.

If Your Benefit Is Affected by IRS Limits

The Internal Revenue Code (IRC) and ERISA impose limitations on benefits provided under the Retirement Plan, both alone and in conjunction with other plans sponsored by PG&E. Generally, these limitations affect only the benefits of certain highly compensated employees. The Plan Administrator will notify you if you are affected by these limits.

If the Retirement Plan becomes less than 80% funded, as determined under applicable IRC rules, the Retirement Plan's ability to pay lump-sum benefits may be restricted. In addition, if the Retirement Plan becomes less than 60% funded, additional payment restrictions may apply and, subject to applicable IRC requirements, all Retirement Plan participants will automatically cease to earn any additional Retirement Plan benefits. The Plan Administrator will notify you if you are affected by these restrictions.

If You Take a Leave of Absence or Go on Long Term Disability

If you are on disability leave or take an approved unpaid leave of absence (including leaves while receiving Short-Term Disability (STD) and/or Paid Family Leave (PFL) Wage Continuation Benefit payments or Workers' Compensation temporary disability payments):

- You'll continue to receive interest credits during your leave.
- If you're a full-time employee immediately prior to the authorized leave of absence, pay credits that would have been earned during the leave period will be granted based on your straight-time rate of pay in effect for your classification immediately before your leave began.
- If you're a part-time employee, no pay credits are earned during the unpaid leave.

If you are receiving Long-Term Disability (LTD) benefits, you will receive pay credits that would have been earned during the LTD period based on the greater of your:

- last active straight-time rate of pay in effect for your classification; or
- LTD benefit.

You are not eligible to take a lump-sum payout or begin receiving an annuity while you are on a leave of absence or LTD. If you have a severance from service and elect to start Retirement Plan benefits, and are later reinstated onto LTD, your pension annuity (if elected) will continue, but your LTD benefit will be reduced by the full pension benefit. If you elect a single lump-sum payout of your Cash Balance Pension, the offset to your LTD benefit will equal the actuarial equivalent value of your cash balance account at the time your lump-sum payment was made.

Claims and Appeals

To receive a benefit from the Retirement Plan, you generally must complete a Pension Elections Form and provide any additional information needed to process your request and withhold taxes. If you believe a violation of ERISA or any other law has occurred, or you seek a remedy under any provision of ERISA or any other law, that

relates in any way to the Retirement Plan, you will be considered a claimant who is subject the Retirement Plan's claims and appeals procedures and the requirement to exhaust these procedures.

Formal Claims Procedures

To make a formal claim, allege a violation of ERISA or any other law, or seek a remedy under any provision of ERISA or any other law, that relates in any way to the Retirement Plan, you must submit a formal claim to the Initial Claim Fiduciary by writing to:

Pacific Gas and Electric Company
Benefits Department
Retirement Plan Claims
300 Lakeside Drive
Oakland, CA 94612

No special form or format is required in submitting a written claim; you or your authorized representative may submit written comments, documents, records, and other information relating to your claim. You may also request, free of charge, access to, or copies of, all documents, records, and other information relevant to your claim. The Initial Claim Fiduciary's review of your claim will take into account all comments, documents, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered during any initial benefit determination by the Benefits Department. Please note, however, that it is the obligation of the Benefits Department, including the Initial Claims Fiduciary, to administer the Retirement Plan fairly, consistently, and in accordance with the provisions of the Retirement Plan.

You will receive written notice of the decision on your claim within 90 days of receipt of the initial claim unless, due to special circumstances, an additional 90 days is required. You will be notified in writing if a 90-day extension is necessary and the circumstances requiring the extension.

If the Initial Claims Fiduciary denies your claim, in whole or in part, you will be notified in writing. Such notification will set forth:

- the specific reason(s) for the denial of the claim;
- a reference to the Retirement Plan provisions which apply to the denial;
- a description of any additional material or information necessary for a participant or beneficiary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the Retirement Plan's claims review procedures and the time limits applicable to such procedures; and
- a statement of the participant's or beneficiary's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review, and after exhausting your administrative remedies under the Retirement Plan.

If you are not satisfied with the Initial Fiduciary's decision on your claim, whether in whole or in part, you may submit a written appeal for review (within 60 days of receiving notice of denial of your claim) to the Employee Benefit Appeals Committee ("EBAC"), the final adjudicator in the appeals process. You or your representative will have, upon request and free of charge, access to, and copies of, all documents, records and other information relevant to your claim. Your appeal must state the reasons for your appeal. You may include all documentation, records and any additional information to support your appeal. If you do not raise an issue on appeal or do not include a piece of evidence, the issue and evidence will not be considered by the EBAC on appeal.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

You will receive a final ruling from EBAC within 60 days of EBAC's receipt of your appeal unless, due to special circumstances, EBAC requires additional time to respond, up to another 60 days. You will be notified in writing if a 60-day extension is necessary and the circumstances for the extension.

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

- the specific reason(s) for denying your appeal;
- a reference to the specific Retirement Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
- a statement describing any voluntary appeals procedures offered by the Retirement Plan (if any) and your right to information about those procedures; and
- a statement of your right to bring a civil action under section 502(a) of ERISA.

A decision on your claim and appeal by the EBAC is final and binding on you and the Retirement Plan.

Exhaustion of Administrative Remedies

The claims review procedures described above are the exclusive claims administrative procedures provided under the Retirement Plan. You must exhaust these claims review procedures with respect to any claim, alleged violation of ERISA or any other law, or remedy sought under any provision of ERISA or any other law, that relates in any way to the Retirement Plan before taking action in another forum.

Legal Action

A claimant or any representative of a claimant may not bring action with respect to a claim, alleged violation of ERISA or any other law, or remedy sought under any provision of ERISA or any other law, that relates to the Retirement Plan in any way in any other forum after the earliest of the date that is:

- one-year from the date of exhaustion of the Retirement Plan's claims review procedures described above;
- one-year from the latest date on which an appeal is permitted to be filed with the EBAC; or
- two years from the date the claimant knew or should have known that a claim existed.

Any such action must be filed in the Federal District Court for the Northern District of California.

The requirements for filing an action on a claim, alleged violation of ERISA or any other law, or remedy sought under ERISA or any other law, that relates to the Retirement Plan are in no way a waiver of the requirement to exhaust the claims review procedures under the Retirement Plan.

Rights under a Collective Bargaining Agreement

As a participant covered by a collective bargaining agreement between your union and the Company, you may use the grievance or adjustment procedure in your collective bargaining agreement to resolve any dispute concerning a question about your service with the Company, or your status or membership under the Plan.

The Pension Benefit Guaranty Corporation

Your pension benefits under the Retirement Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under a terminated plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- normal and early retirement benefits;

- disability benefits if you become disabled before the pension plan terminates; and
- certain benefits for your survivors.

The PBGC generally does not cover:

- benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates;
- some or all of the benefit increases and new benefits based on plan provisions that have been in place for fewer than five years at the time the plan terminates;
- benefits that are not vested because you have not worked long enough for the company;
- benefits for which you have not met all of the requirements at the time the plan terminates;
- certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and
- non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington DC 20005-4026 or call 202-326-4000 or 1-800-400-7242. TTY/TDD users may call the **federal relay service at 1-800-877-8339** and ask to be connected to 1-800-400-7242. Additional information about the PBGC's pension insurance program is available through the PBGC's website at pbgc.gov.

Or contact:

Pacific Gas and Electric Company
Benefits Department
300 Lakeside Drive
Oakland, CA 94612

1-800-700-0057

Tax Considerations

All Plan distributions are considered taxable income and are subject to normal federal and (if applicable) state and/or local income taxes.

Annuity payments are subject to income tax withholding at ordinary income tax rates.

If you elect a lump-sum payment to be paid to you, the Company must withhold 20% federal tax from your distribution unless you elect a direct rollover. This withholding is sent to the IRS and is credited as part of your tax withholding for the year in which you receive your distribution.

If you're under age 59½ and don't roll over your lump-sum payment to an Individual Retirement Account (IRA) or other tax-qualified retirement plan, your distribution may be subject to a 10% federal income tax penalty in addition to the 20% withholding tax. State income tax penalties may also apply. However, the additional 10% IRS penalty does not apply if your payment is:

- paid to you because you leave the Company during or after the year in which you reach age 55;
- paid to you after you're permanently and totally disabled;
- paid to you as equal (or almost equal) payments over your life expectancy (or the combined life expectancies of yourself and your beneficiary);
- used to pay certain medical expenses; or
- paid to your beneficiary after your death.

Tax laws are complicated and subject to frequent change. You should consult a qualified tax advisor before making your distribution election.

Retirement Savings Plan

The PG&E Corporation Retirement Savings Plan for Union-Represented Employees ("the Plan") offers you a valuable way to save for your future, through before-tax and after-tax contributions, as well as employer contributions.

"Company" Defined

Throughout this Retirement Savings Plan section, unless otherwise stated, reference to "Company" or "PG&E" means PG&E Corporation.

The Plan offers eligible employees of PG&E Corporation, Pacific Gas and Electric Company and other designated subsidiaries a tax-advantaged way to save for retirement. The Plan also includes an additional component — an Employee Stock Ownership Plan (ESOP), which is linked to the PG&E Corporation Stock Fund investment option (see "PG&E Corporation Stock Fund Information" for more information). The Plan is intended to qualify under section 401(a) and section 401(k) of the Internal Revenue Code (IRC). The Plan is also intended to satisfy the requirements of section 404(c) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), including all applicable regulations issued by the United States Department of Labor and the United States Treasury Department.

This Summary Plan Description contains a summary of your rights and benefits under the Plan. It is not meant to interpret, extend or change the Plan in any way. A copy of the Plan is on file with the Administrator and may be reviewed by any participant or beneficiary at any reasonable time.

The Plan document governs in the event of any discrepancy between this Summary Plan Description and the actual provisions of the Plan document. PG&E Corporation reserves the right to change, amend, or terminate the Plan at any time.

This Retirement Savings Plan for Union-Represented Employees includes securities that have been registered under the Securities Act of 1933. The prospectus covering these securities can be found at mypgebenefits.com.

If you have questions about the Plan or the Summary Plan Description, please contact Fidelity at **1-877-743-4015** or the Plan Administrator (see *Rules, Regulations & Administrative Information* for contact information).

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Retirement Savings Plan at a Glance

- The Retirement Savings Plan for Union-Represented Employees, sometimes referred to as the 401(k) plan, offers a tax-advantaged way for you to save for retirement. You may contribute a portion of your salary to the Plan on a before-tax basis, Roth after-tax basis, an after-tax basis, or a combination of all three.
- Beginning January 1, 2013, certain aspects of participation in the Plan will depend on the form of pension benefit that you are earning under the Pacific Gas and Electric Company Retirement Plan (the Retirement Plan), or your date of hire or rehire. If you are participating in the Cash Balance Pension, or generally were hired or rehired after 2012 into an eligible position, you will be automatically enrolled in the Plan and when you have completed one year of service you will be eligible for a higher employer match. Please see *Retirement Plan — Cash Balance Pension Benefit* for more information about your pension benefits.
- After an eligible employee has completed one year of service and makes contributions to the Plan, certain participant contributions are eligible for matching employer contributions. The company match will be made in cash and invested based on your investment elections on file with Plan's service provider, Fidelity Investments (Fidelity). If there are no investment elections on file, the matching employer contributions will be invested in an RSP Target Date Fund that has a target retirement date closest to the year in which you reach age 65.
- You are fully vested in your contributions to the Plan and in all employer contributions credited to your account, together with any earnings.
- Contributions made on a before-tax basis are made before income taxes are withheld, reducing your taxable income. Income taxes on before-tax contributions and any earnings are deferred (postponed) until you withdraw the money from the Plan. Although after-tax contributions are deducted after income taxes are withheld, taxes on earnings are deferred while the amounts remain in the Plan.
- Contributions made as Roth contributions are made on an after-tax basis. Similar to regular after-tax contributions, Roth contributions are deducted after income taxes are withheld. However, there are no taxes on earnings when you withdraw the Roth contributions if certain holding requirements are met.
- The Plan offers three tiers of investment options from which to choose. Your individual investment strategy should reflect your personal savings goals and tolerance for financial risk. Ultimately, your investment choice is an individual decision.
- If you need professional advice on how to invest contributions to the Plan, you should seek assistance from a financial consultant or tax advisor. You may also obtain investment advisory assistance through the services provided by Edelman Financial Engines (see "Investment and Advisory Services" for more information).

Participating in the Plan

Who's Eligible

In general, the Plan covers those union-represented employees of participating employers within PG&E Corporation whose collective bargaining agreement provides for participation in the Plan. Certain classifications of union-represented employees, such as Hiring Hall, Temporary Additional, Probationary Intermittent, and Outage classifications are not eligible to participate in the Plan.

You may participate in the Plan for as long as you remain an eligible employee of a participating employer within PG&E Corporation.

If you are rehired by a participating employer within PG&E Corporation, and you had previously worked more than 12 months for PG&E or you had left PG&E less than 12 months before your rehire date, you will receive credit for your past service.

Enrolling in the Plan

You are eligible to participate in the Plan when you start work in an eligible job classification. You may enroll and elect to have before-tax, Roth, after-tax, or a combination of all types of contributions deducted from your pay in an amount up to 50% of your covered compensation.

Your elected contributions to the Plan will be deducted from your **pay** as soon as practicable after you enroll or, if applicable, once you are automatically enrolled in the plan (see "Automatic Enrollment in the Plan").

After your personal employment data is processed, you will receive an enrollment kit from the Plan's service provider, Fidelity Investments (Fidelity). You can enroll through Fidelity NetBenefits℠ online account services at 401k.com. You may also enroll by calling Fidelity at1-877-743-4015. You may choose the percentage of your covered compensation that you wish to contribute to the Plan, from 0% up to 50%, and your investment elections. If you don't provide investment instructions for your Plan contributions, including if you are automatically enrolled in the Plan, they will be invested in the Target Date Fund with a target date closest to your 65th birthday until you specify otherwise (see "Investment Options").

Automatic Enrollment in the Plan

You will be automatically enrolled in the Plan if you are an:

- Eligible employee hired or rehired on or after January 1, 2013, or
- Eligible employee hired or rehired before January 1, 2013, who elected to participate in the Cash Balance Pension formula of the Pacific Gas and Electric Retirement Plan ("Retirement Plan"), effective as of January 1, 2014.
- You'll be automatically enrolled in the 401(k) plan at an 8% contribution level. You can change, stop or re-start your contributions at any time.

All other groups of employees, including eligible employees who continue to participate in the Final Pay pension formulas in the Retirement Plan are not covered by automatic enrollment and must complete the enrollment process to begin making contributions to the Plan (see "Enrolling in the Plan," above).

If automatic enrollment applies to you, it will work as follows:

If you are hired or re-hired on or after January 1, 2013: You are automatically enrolled for before-tax deductions at a rate of 8% of your covered compensation. Your automatic enrollment will be effective at the beginning of the first pay period that starts 30 days after your hire date. You will become eligible to receive matching contributions one year after your hire date, or as soon thereafter as practicable, unless you specifically elect not to participate in the Plan or elect to contribute a different rate of your covered compensation.

After your personal employment data is processed, you will receive an enrollment kit from the Plan's service provider, Fidelity Investments (Fidelity). Your enrollment kit will indicate your automatic enrollment date, before-tax contribution percentage, and the default investments that will apply. This kit will also tell you how to change the percent of pay you are contributing, how to make your personal investment elections, and how to decline to participate in the Plan. If you enroll on your own before your automatic enrollment effective date, there will be no change to your contribution or investment elections.

If you elected to participate in the Cash Balance Pension during the one-time pension choice period in 2013: The automatic enrollment process applies to you each year on January 1. If you are contributing less than 8% of your covered compensation as of January 1 of any calendar year, you will be automatically enrolled for before-tax deductions at the 8% contribution level as of the first payroll period in January, or as soon thereafter as practicable, unless you specifically elect not to participate in the Plan or elect a different contribution rate.

Re-enrollment of Automatically Enrolled Participants: If automatic enrollment applies to you, and you reduce your contribution percentage below 8% of covered compensation, you will be automatically enrolled at the 8% contribution level in January of the next plan year. Each time you are re-enrolled, you may elect not to participate in the Plan, or elect to contribute a different rate of your covered compensation.

If this is the first time you are automatically enrolled in the Plan: You may request a refund of your automatic enrollment contributions no later than 90 days after the date on which the first automatic enrollment contribution

is made. You will receive a distribution of the amounts deducted from your pay under this automatic enrollment provision. The distribution will be increased to reflect earnings on your contributions, or decreased to reflect investment losses, but you will forfeit any company matching contribution and applicable earnings on such company match. Your request to receive a refund will also be considered an election to defer 0% of your covered compensation until you elect to begin making contributions or until the next automatic re-enrollment occurs.

Contribution refunds are subject to income tax when distributed, but early distribution penalty taxes do not apply. These amounts are not eligible for a tax-deferred rollover.

By law, you may only request a refund the first time the automatic enrollment process under this Plan is applied to you. This is true whether or not you elected a refund when you were automatically enrolled for the first time, or if you are a rehire who was automatically enrolled in the Plan during a period of previous employment.

Beneficiary Designation

Once you are participating in the Plan, you should designate a beneficiary. This may be done online at Fidelity NetBenefits℠ at 401k.com. If you do not have online access, you may contact Fidelity at 1877-743-4015 to request a beneficiary designation form.

If you do not designate a beneficiary, your default beneficiary will be your spouse if you are married, or your estate if you are not married. If you are married and designate anyone other than your spouse as a beneficiary, you must submit notarized evidence of spousal consent. You should review your beneficiary designations regularly, and any time your circumstances change (such as marriage, divorce, or birth or adoption of a child). You may change your beneficiary designation at any time.

For purposes of the Plan, you have a "spouse" if you are legally married under applicable law of a state or foreign jurisdiction, including a same-sex couple. However, in accordance with IRS guidance, a registered domestic partnership, civil union, or other similar formal relationship that is not denominated as a marriage under the law is not treated as being legally married for purposes of the Plan.

Contributions

This section contains information about the types of contributions you may make to your account. To start, stop, or change the amount of your contributions to the Plan, you can log on to Fidelity NetBenefits℠ online account services at 401k.com, or call Fidelity at **1-877-743-4015** to speak with a Participant Services Representative or use the automated voice response system.

PG&E makes every effort to send your contributions and the company matching contribution to Fidelity within several business days, or as soon as practicable after your payroll date. When Fidelity receives the funds, they invest your contributions based on the investment options you selected.

Vesting

You are 100% vested at all times in the contributions you make to your own account. You are also 100% vested at all times in employer contributions credited to your account.

Employee Contribution

You may elect to contribute any percentage of your covered compensation in 1% increments, from 1% to 50%,on a before-tax, Roth, or after-tax basis, or a combination of all three.

Note: Contributions to the PG&E Corporation Stock Fund are limited to 20%. If your existing account balance includes more than 20% in the PG&E Corporation Stock Fund, you are not required to sell the funds; however, you will not be able to contribute any additional funds to the stock fund.

Covered compensation includes:

- straight-time pay for hours worked and for temporary upgrades;
- shift and nuclear premiums at the straight-time rate;

- vacation pay (including vacation upon termination or retirement), sick pay, holiday pay, and pay during an approved leave of absence, including (for ESC-represented employees only) employer-paid Wage Continuation Benefit payments for Short-Term Disability (STD) or Paid Family Leave (PFL) leaves of absence;
- inclement weather pay;
- differential pay for military service;
- pay for other time off with permission; or
- employer-paid benefits for long-term disability (LTD) and supplemental benefits for industrial injury.

Covered compensation does not include:

- pay or shift and nuclear premiums for more than 40 hours a week;
- overtime;
- one-time payments including bonus and incentive pay and recognition awards;
- reimbursements
- severance payments, or any lump-sum payments;
- per diem allowances and other special fees or allowances; or
- payments from any other benefit plan including, but not limited to, benefits from the 2022 Pacific Gas and Electric Voluntary Separation Plan, or provided through insurance or that are not considered to be taxable wages paid by an employer, including insured short-term disability and long-term disability benefits, workers' compensation and state disability.

You may start, stop, or change the amount of your before-tax, Roth, after-tax, or catch-up contributions to the Plan at any time. You can do so by logging on to Fidelity NetBenefits℠ online account services at 401k.com, or by calling Fidelity at **1-877-743-4015** and speaking with a Participant Services Representative or using the automated voice response system.

Employee contributions may be directed to any one or more of the investment fund options available under the Plan (see "Investment Options").

Contribution investment elections must be made to any fund or combination of funds in 1% increments and must equal 100% of your elected contribution amount. Changes to contribution amounts are subject to payroll deadlines, but are generally effective within 30 days of receipt of your elections.

Catch-Up Contribution

Participants who will be age 50 or older before the close of the plan year (December 31) are eligible to make catch-up contributions to the Plan in that plan year or thereafter. Catch-up contributions are in addition to your regular Plan contributions. If eligible, you may elect a catch-up contribution from 1% to 50% of your covered compensation up to the maximum dollar amount allowed by law (which amount is periodically adjusted by the Treasury Department). Generally, you may make catch-up contributions as before-tax or Roth contributions. However, effective January 1, 2026, if your prior-year FICA wages (as reported in Box 3 of your Form W-2) from the Company exceed a certain amount ($150,000 in 2025 FICA wages, as may be adjusted from year to year), any catch-up contributions that you make must be made as Roth contributions.

In order for the amounts you elect to be eligible as catch-up contributions, you must reach one of the following limits (see "Contribution Limits"):

- Visit mypgebenefits.com/retirement to view the current maximum catch-up contribution amount. Plan contribution percentage limit of 50% of covered compensation.

If you do not reach one of these limits, your catch-up contributions will be considered regular plan contributions. Catch-up contributions are not eligible for matching employer contributions.

Your catch-up contributions are not counted towards the IRC section 401(k) limit or annual additions limit.

Matching Employer Contributions

Matching employer contributions are made on behalf of eligible employees who contribute to the Plan and are a way in which PG&E shares in providing retirement savings for you. Matching contributions are made each payroll period that you contribute to the Plan and are eligible to receive matching contributions.

You become eligible for matching employer contributions when you have completed 12 months of service and you make contributions to the Plan. The amount of matching employer contributions that you are eligible to receive is determined based on the type of pension you are earning under the Retirement Plan (see *Retirement Plan — Final Pay Pension Benefit* for more information on the pension formulas.)

If you are earning a Final Pay Pension under the Retirement Plan, matching employer contributions will be made in the following percentages according to your years of service:

Length of Service	Matching Employer Contribution for Final Pay Participants
1 to 3 years of service	60% of the employee's before-tax and/or after-tax contributions that do not exceed 3% of the employee's covered compensation per pay period.
3 years of service or more	60% of the employee's before-tax and/or after-tax contributions that do not exceed 6% of the employee's covered compensation per pay period.

A "year of service" is the completion of 12 months of employment within PG&E. If you have terminated employment and are rehired, your past service may be considered when determining your years of service. If you had previously worked more than 12 months before your employment ended, or you are rehired within 12 months of your termination date, you will receive credit for your past service.

If you are earning a Cash Balance Pension under the Retirement Plan, you are eligible for a matching employer contribution of $0.75 per dollar on each dollar that you contribute, up to 8% of covered compensation. If you are hired or rehired after December 31, 2012, you are eligible for this company contribution when you have completed one year of service. If you elected to move to the Cash Balance Pension during the one-time Pension Choice period in 2013, you are eligible for the company-matching contribution of $0.75 per dollar on your contributions up to 8% of covered pay, when you begin participation in the Cash Balance Pension as long as you have completed one year of service.

Hired Before 2013:			
Union-represented employees	You become eligible for the company match after you have 12 months of service.	1%	0.6%
	1–3 years of service: PG&E will match $0.60 per $1 you contribute up to 3% of your eligible pay.	2%	1.2%
		3%	1.8%
	3+ years of service: PG&E will match $0.60 per $1 you contribute up to 6% of your eligible pay.	1%	0.75%
		2%	1.5%
		3%	2.25%
		4%	3%
		5%	3.75%
		6%	4.50%

Hired After 2013:			
Union-represented employees	You become eligible for the company match after you have **one year of service**.	1%	0.75%
	After that, PG&E will match $0.75 per $1 you contribute up to 8% of your eligible pay.	2%	1.5%
		3%	2.25%
		4%	3%
		5%	3.75%
		6%	4.50%
		7%	5.25%
		8%	6%

To receive the maximum matching employer contribution, you must contribute the maximum percentage of your pay that is eligible for the match each pay period. You must contribute at least 3% or 6% of your covered compensation (for Final Pay Pension participants) depending on length of service, or 8% of your covered compensation (for Cash Balance Pension participants) to receive the maximum employer match per pay period. Below is an illustrative example comparing two participant contribution scenarios and the implications for company matching:

- Participant: Cash Balance Pension participant
- Company Match: $0.75 per dollar on your contributions up to 8% of covered pay per pay period
- Participant Pay: $120,000 or $$5,000 per pay period

	Scenario A		Scenario B	
Pay Period	Participant Contributions	Company Match	Participant Contributions	Company Match
January 1	$731	$300	$1,585	$300
January 15	$731	$300	$1,585	$300
February 1	$731	$300	$1,583	$300
February 15	$731	$300	$1,583	$300
March 1	$731	$300	$1,583	$300
March 15	$731	$300	$1,583	$300
April 1	$731	$300	$1,583	$300
April 15	$731	$300	$1,583	$300
May 1	$731	$300	$1,583	$300
May 15	$731	$300	$1,583	$300
June 1	$731	$300	$1,583	$300
June 15	$731	$300	$1,583	$300
July 1	$731	$300	$0	$0

	Scenario A		Scenario B	
Pay Period	Participant Contributions	Company Match	Participant Contributions	Company Match
July 15	$731	$300	$0	$0
August 1	$731	$300	$0	$0
August 15	$731	$300	$0	$0
September 1	$731	$300	$0	$0
September 15	$731	$300	$0	$0
October 1	$731	$300	$0	$0
October 15	$731	$300	$0	$0
November 1	$731	$300	$0	$0
November 15	$731	$300	$0	$0
December 1	$731	$300	$0	$0
December 15	$731	$300	$0	$0
Total	$19,000	$7,200	$19,000	$3,600

You are 100% vested at all times in matching employer contributions credited to your account.

The matching employer contribution is made in cash and invested based on your investment elections on file with Plan's service provider, Fidelity Investments (Fidelity). If there are no investment elections on file, the matching employer contributions will be invested in an RSP Target Date Fund that has a target retirement date closest to the year in which you reach age 65.

For more information about your investment options for matching employer contributions, (see "Investment Options").

Rollover Contributions from Previous Employer Plans

As long as you are eligible to make contributions to the Plan, you may rollover (either directly or within 60 days upon receipt of the distribution) a taxable or non-taxable distribution from most qualified retirement plans offered by a previous employer — including plans from tax-exempt non-profit organizations (IRC section 403(b) plans) and state and local governments (IRC section 457 plans) — or from an Individual Retirement Account (IRA). The Plan reserves the right to refuse any rollover from a participant that would disqualify the Plan under the Internal Revenue Code (IRC).

You may invest rollover contributions in any of the investment options available under the Plan. Rollover contributions will be accounted for separately from any other contributions. Rollover contributions and earnings may be withdrawn at any time, but may be subject to tax and/or tax penalties if withdrawn early and, if eligible, not re-deposited into a tax-qualified retirement plan.

Rollover contributions are not eligible for matching employer contributions.

Contribution Limits

Limit on Annual Before-tax and Roth Employee Contributions

Your before-tax and Roth contribution amounts (other than catch-up contributions) are limited by rules contained in IRC section 402(g). Visit mypgebenefits.com > Financial Health > 401(k) Retirement Savings Plan to see the current before-tax and Roth contribution limits for the 401(k) plan. This limit is adjusted periodically for inflation.

Note that this limit applies to any before-tax and Roth contributions you have made in the same calendar year, including any before-tax and Roth contributions you made under a previous employer's plan. You are responsible for ensuring that your total before-tax and Roth contributions from the combined plans do not exceed the IRC section 402(g) limit.

If you reach the annual limit before the end of the year and want to continue to receive the matching employer contribution for the entire year, you should consider a provision under the Plan called the "spillover election." This election automatically changes your before-tax contributions to after-tax contributions (Roth contributions for highly paid participants) when you reach the before-tax limit. You may make the spillover election through Fidelity NetBenefits℠ online account service (401k.com) or by contacting Fidelity at **1-877-743-4015**. If you make a spillover election, your original before-tax contribution elections will resume automatically in January of the following year unless you specify otherwise.

Limit on Annual Plan Contributions

All employee before-tax, Roth and after-tax contributions, excluding catch-up contributions, as well as all employer contributions, may not exceed the IRC annual additions limit, which is the lesser of:

(i) 100% of your compensation; or

(ii) a dollar amount specified under IRC section 415 (visit mypgebenefits.com > Financial Health > 401(k) Retirement Savings Plan for the current limit), adjusted periodically for inflation.

If you reach the IRC section 415 limit before the end of any calendar year, your contributions to the Plan (except for eligible employee catch-up contributions) will be stopped.

Other Contribution Limits

IRC section 401(a)(17) specifies a dollar limit for annual covered compensation on which contributions may be made, which is adjusted periodically for inflation.

In addition, the average contribution percentages made by and on behalf of "highly compensated" employees may not exceed the average contribution made by and on behalf of "non-highly compensated" employees by more than the amounts set forth in IRC section 401(k). The amount is updated periodically and may be viewed on visit mypgebenefits.com > Financial Health > 401(k) Retirement Savings Plan.

Corrective Amounts for Excess Contributions

If the IRC section 402(g) or section 401(k) limits described above are exceeded within the Plan, the Plan Administrator will notify you and will refund any excess contributions by April 15 of the year following the year in which the excess contributions were made. Any earnings or losses on refunds of participants' excess contributions will be allocated in accordance with IRS regulations. However, if you are eligible for catch-up contributions, any excess contributions will be re-characterized as catch-up contributions (to the extent allowed by law).

You are responsible for ensuring that your contributions to all employer plans in a single calendar year do not exceed applicable IRC limits. If your contributions to all employer plans do exceed the applicable IRC limits, you must contact the Plan Administrator to request a refund.

Roth In-Plan Conversion Contributions

Active or terminated participants and spouses or alternate payees under a QDRO may convert their before-tax, before-tax catch-up, after-tax, rollover and employer matching contributions into a Roth in-plan conversion contribution. Any election to convert is irrevocable. Any previously untaxed amounts will be included in gross income in the year in which the conversion is made. The only thing that changes is the tax treatment of these contributions – the converted amounts will be treated as Roth contributions - any limitations on form or timing of distribution remains the same as the original contributions.

Investing

This section describes the different investment options available to you. Specific information about your individual account is available online at Fidelity Investments' website, NetBenefits℠ online account services, at 401k.com, or by telephone from Fidelity' at **1-877-743-4015**.

Investment and Advisory Services

Edelman Financial Engines is an unbiased, independent advisory firm which the Plan Administrator has selected to provide Plan participants with support and assistance in making investment decisions. For a description of the firm's services, see "Edelman Financial Engines."

Investment Options

The RSP offers a number of investment options for building an individual investment portfolio designed to achieve your retirement savings goals. You should keep in mind several factors when determining your individual investment strategy and deciding which investment funds meet your needs. Primarily, you should weigh your tolerance for risk against your personal savings goals and how long you have to reach them. You should also consider your overall financial picture, including any external personal investments. Regardless of which funds you choose, it is always your responsibility to ensure that your fund choices meet your investment objectives. It is also important to periodically review your investments, your objectives, and the investment options under the Plan to help ensure that your retirement savings will meet your retirement goals.

To help achieve long-term retirement security, you should also give careful consideration to the benefits of a well-balanced and diversified investment portfolio. Spreading your assets among different types of investments can help you achieve a favorable rate of return, while minimizing your overall risk of losing money. This is because market or other economic conditions that cause one category of assets, or one particular security, to perform well often cause another asset category, or another particular security, to perform poorly. The Department of Labor and the Internal Revenue Service advise that if you invest more than 20% of your retirement savings in any one company or industry, such as the PG&E Corporation Stock Fund, your savings may not be properly diversified. Although diversification is not a guarantee against loss, it is an effective strategy to help you manage investment risk.

The Employee Retirement Income Security Act of 1974 (ERISA) imposes certain duties on the parties who are responsible for the operation of the Plan. These parties, called fiduciaries, have a duty to manage Plan assets in a prudent manner. However, an exception exists for plans which comply with section 404(c) of ERISA and permit a participant or beneficiary to exercise control over the assets in his or her account and choose from a broad range of investment alternatives. This Plan is intended to be an ERISA section 404(c) plan. This means that you, not the Plan Administrator, the Company or any other employee, are responsible for investment decisions relating to the assets in your account under the Plan.

Investment information, including prospectuses, fund descriptions and investment performance, can be found by logging on to Fidelity NetBenefits℠ online account services at 401k.com or by calling Fidelity at **1-877-743-4015**.

RSP investment options are structured in three tiers:

- Tier 1: Target Date Funds
- Tier 2: Core Funds
- Tier 3: Self-Directed Account

Tier 1: Target Date Funds

Tier 1 provides a suite of eleven individual funds that each provides a broadly diversified portfolio consisting principally of U.S. and international common stock and marketable fixed income securities with an asset allocation that is suitable for a participant with a retirement date in the fund's specified target year. The asset allocation is established by the fund's investment manager and is incrementally adjusted to reflect an appropriate balance of opportunities for growth and stable income relative to the stated target retirement date. The RSP Retirement Income Fund is designed for investors who have reached their retirement date. The strategy

is comprised mostly of bond funds to provide stability and income; it also includes an allocation to equities to provide diversification and some growth during retirement. You should be aware that the RSP Retirement Income Fund will still be exposed to fluctuations in the security markets.

Each Target Date Fund has its own fund description which describes the investment mix and strategy of each fund. These funds are based on well-established investing concepts related to diversification and risk. However, these funds do not guarantee a positive return or adequate funds throughout retirement. Be sure to review the applicable fund description before making your investment decision.

The Target Date Funds are the Plan's default investment option(s). If you do not provide instructions on how you want your contributions invested, they will be invested in the Target Date Fund with a target date closest to your 65th birthday. For participants over age 65, they will be invested in the RSP Retirement Income Fund.

PG&E provides oversight and monitoring of the Target Date Funds investment manager to ensure that the funds remain consistent with their stated objectives. Current information regarding fund performance and fees is available through Fidelity NetBenefits℠ at 401k.com or by calling Fidelity at **1-877-743-4015**.

Tier 2: Core Funds

The Core Funds include the following eleven investment options:

- RSP Money Market Fund
- RSP Bond Index Fund
- RSP U.S. Government Bond Index Fund
- RSP Large Company Stock Index Fund
- RSP Small Company Stock Index Fund
- RSP International Stock Index Fund
- PG&E Corporation Stock Fund

PG&E provides oversight and monitoring of the Core Fund managers to ensure that the funds remain consistent with their stated objectives.

RSP Money Market Fund

The Fund seeks to offer safety of principal by investing in short-term government and non-government debt securities.

The Fund invests principally in the following instruments: U.S. Treasury bills, notes and bonds (which are direct obligations of the U.S. government).

An investment in a money market fund is not insured or guaranteed by the Federal Deposit Insurance Corporation (FDIC) or any other government agency. Although the fund seeks to preserve the value of your investment at $1.00 per share, it is possible to lose money by investing in the fund.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at 401k.com or by calling Fidelity at **1-877-743-4015**.

RSP Bond Index Fund

This Fund seeks to match the returns of the Barclays Capital Aggregate Bond Index, a benchmark representing the broad, intermediate maturity, investment-grade U.S. bond market.

The Fund invests primarily in government, corporate, mortgage-backed, and asset-backed fixed-income securities of intermediate maturity; all bonds are investment grade.

Since it is an index fund, the Fund invests in a well-diversified portfolio that is representative of the broad domestic bond market.

The performance of the Fund depends primarily on the value of its bond holdings, changes in interest rates, and the credit quality and maturity of its investments. In general, bond prices tend to increase when interest rates decrease, and vice versa. This price fluctuation can produce decreases in principal value if interest rates rise; this effect is often most pronounced for longer maturity bonds. Therefore, the Fund's investment in high-quality bonds with an intermediate-term maturity will generally produce steady income with reduced risk compared with funds that invest in longer maturity bonds.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at 401k.com or by calling Fidelity at **1-877-743-4015**.

RSP U.S. Government Bond Index Fund

This Fund seeks to match the returns of the Barclays Capital US Government Bond Index, a benchmark representing investment-grade fixed income securities issued by the United States government or its agencies.

The Fund invests in a sample of bonds in the Barclays Capital US Government Bond Index in proportion to their weight in the index. All bonds are investment grade. Since it is an index fund, the Fund invests in a well-diversified portfolio that is representative of the U.S. government and agency intermediate maturity bond market.

The performance of the Fund depends primarily on the value of its bond holdings, changes in interest rates, and the credit quality and maturity of its investments. In general, bond prices tend to increase when interest rates decrease, and vice versa. This price fluctuation can produce decreases in principal value if interest rates rise; this effect is often most pronounced for longer maturity bonds. Therefore, the Fund's investment in high-quality bonds with an intermediate-term maturity will generally produce steady income with reduced risk compared with funds that invest in longer maturity bonds.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at 401k.com or by calling Fidelity at **1-877-743-4015**.

RSP Large Company Stock Index Fund

This Fund seeks to match the performance of the Standard & Poor's 500® Index, a benchmark representing the large-capitalization U.S. stock market.

The Fund invests in all 500 stocks in the S&P 500® Index in proportion to their weightings in the index. The S&P 500® Index provides exposure to about 78% of the market value of all publicly-traded common stocks in the United States. The strategy of investing in the same stocks as the S&P 500® Index assures a return similar to the benchmark, minimizes the need for trading, and results in lower expenses.

The performance of the Fund depends on the value of its holdings. Stock values may vary from day to day in response to the corporate performance of individual companies and general market and economic conditions. The Fund is diversified to minimize the impact of underperformance by a single company. In the short term, stock values may be volatile, but over the long term, they have the potential for higher returns than bond or short-term investments.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at 401k.com or by calling Fidelity at **1-877-743-4015**.

RSP Small Company Stock Index Fund

This Fund seeks to match the performance of the Russell Small Cap Completeness Index, a benchmark representing the mid-and small-capitalization sectors of the U.S. stock market.

The Fund invests in all of the stocks in the Russell Small Cap Completeness Index in proportion to their weightings in the index. These stocks represent about 22% of the market value of all publicly-traded common stocks in the United States. The strategy of investing in the same stocks as the Russell Small Cap Completeness Index assures a return similar to the benchmark, minimizes the need for trading, and results in lower expenses.

The performance of the Fund depends on the value of its holdings. Stock values may vary from day to day in response to the corporate performance of individual companies and general market and economic conditions. The Fund is diversified to minimize the impact of underperformance by a single company. In the short term, stock values may be volatile, but over the long term, they have the potential for higher returns than bond or short-term investments.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at 401k.com or by calling Fidelity at **1-877-743-4015**.

RSP International Stock Index Fund

This Fund seeks to match closely the performance of the Morgan Stanley Capital International World ex-US (MSCI World Ex-US) Index, a benchmark representing the large-capitalization sectors of developed stock markets outside of the United States.

The Fund typically invests in all the stocks in the MSCI World ex-US Index in proportion to their weightings in the index. The strategy of investing in the same stocks as the MSCI World ex-US Index assures a return similar to the benchmark, minimizes the need for trading, and results in lower expenses.

The performance of the Fund depends on the value of its holdings. Stock values may vary from day to day in response to the corporate performance of individual companies and general market and economic conditions. The Fund is diversified to minimize the impact of underperformance by a single company. In the short term, stock values may be volatile, but over the long term, they have the potential for higher returns than bond or short-term investments. Investment in the Fund is made in U.S. dollars; therefore, the Fund is also exposed to fluctuations in foreign currencies.

Be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description can be found on NetBenefits℠ at 401k.com or by calling Fidelity at **1-877-743-4015**.

You are not allowed to make more than one exchange into or out of the RSP International Stock Index Fund in any 30-day period.

PG&E Corporation Stock Fund

This Fund is designed to provide you with an opportunity to own part of PG&E Corporation and to share in the investment performance of PG&E Corporation common stock. PG&E Corporation common stock is listed on the New York Stock Exchange (NYSE) under the symbol "PCG."

The PG&E Corporation Stock Fund is invested primarily in PG&E Corporation common stock, with a small amount of short-term investments that is held to provide the liquidity needed to accommodate buy and sell orders on a daily basis.

Note: Contributions to the PG&E Corporation Stock Fund are limited to 20%. (Reinvested dividends are not subject to the 20% limit.) If your existing account balance includes more than 20% in the PG&E Corporation Stock Fund, you are not required to sell the funds; however, you will not be able to contribute any additional funds to the stock fund. Under the accounting method used for the Fund, each participant owns units of the Fund rather than shares of stock. Each unit represents an interest in the Fund's PG&E Corporation common stock and a small amount of the Fund's short-term investments.

Each day, the value of each unit is adjusted to reflect each participant's interest in the change in the price of PG&E Corporation common stock, any dividend activity, and interest earned on the short-term investments held by the PG&E Corporation Stock Fund. Dividends are used to either purchase additional units for participants or pay participants in cash (see "PG&E Corporation Stock Fund Information").

The Fund is not diversified and effectively invests in a single security. As a result, the Fund's returns will be driven principally by the performance of PG&E Corporation common stock.

PG&E has filed a registration statement with the Securities and Exchange Commission covering the offer and sale of PG&E Corporation common stock under the Plan. In addition to reading this summary plan description, you should read the description of the Fund which is contained in a separate prospectus before investing in the

PG&E Corporation Stock Fund. This prospectus can be found at mypgebenefits.com. Also, be sure to review the fund description for more information including the Fund's investment manager, applicable fees and investment return experience before making your investment decision. The fund description and prospectus can be found on NetBenefits℠ at 401k.com or by calling Fidelity at **1-877-743-4015**.

Tier 3: Self-Directed Account (Fidelity BrokerageLink)

Tier 3 is a self-directed brokerage account that provides investment choices beyond the funds in Tiers 1 and 2 of the Plan. Through the Self-Directed Account, you can invest in mutual funds available in Fidelity FundsNetwork as well as exchange-traded funds through the use of Fidelity BrokerageLink.

If you wish to invest in funds that are available through the Self-Directed Account, you must open a BrokerageLink account directly with Fidelity Brokerage Services LLC (or FBSLLC). The terms of the brokerage account, including fees, are established in written agreements between FBSLLC and participants. FBSLLC establishes the terms and provisions applicable to Fidelity BrokerageLink holdings and transactions.

FBSLLC retains full control over the mutual funds and exchange-traded funds made available through Fidelity's FundsNetwork. Mutual funds and exchange-traded funds may be added or closed at the sole discretion of FBSLLC. Neither the Plan Administrator nor PG&E Corporation selects or monitors the offering of specific mutual funds or exchange-traded funds through BrokerageLink or the terms and provisions applicable to Fidelity BrokerageLink holdings and transactions. Therefore, participants choosing to enroll in BrokerageLink are fully responsible for their investment decisions, including all appropriate research regarding the suitability of investing in any such funds.

You cannot use the Self-Directed Account to invest in PG&E Corporation common stock or in any of the Plan's other Tier 1 or Tier 2 funds. Participant account balances invested in a Self-Directed Account must be exchanged into one or more of the Plan's Tier 1 or Tier 2 funds before such amounts are available for a participant loan, withdrawal or distribution.

For additional discussion of the Self-Directed Account and BrokerageLink, please refer to the BrokerageLink Fact Sheet available under the Plan Information and Documents section, and the BrokerageLink Brochure and materials available under the BrokerageLink section of NetBenefits℠ at 401k.com (click on Quick Links > BrokerageLink. Or, you may contact Fidelity at **1-877-743-4015** and ask to be transferred to a BrokerageLink representative.

PG&E Corporation Stock Fund Information

On January 11, 2019, the PG&E Corporation Employee Benefit Committee engaged Gallagher Fiduciary Advisors, LLC ("Gallagher") to assume fiduciary responsibility for the PG&E Corporation Stock Fund ("Stock Fund") as an investment option within the 401(k) Plan.

As an independent third-party fiduciary, Gallagher has the full authority to make any and all decisions about the Stock Fund, including whether to continue to permit further participant investment in the Stock Fund.

The Plan contains an Employee Stock Ownership Plan (ESOP). Under the ESOP, participants who hold an investment in the PG&E Corporation Stock Fund on the record date for the payment of a dividend on PG&E Corporation common stock may elect to:

- Reinvest the dividends in additional units of the PG&E Corporation Stock Fund,
- Receive the dividends in cash, or
- Choose a combination of both.

Unless you instruct Fidelity to pay the dividends in cash, dividends will be reinvested in additional units of the PG&E Corporation Stock Fund. Once made, this election remains in effect until changed. You may change your dividend election each quarter. Dividends are payable only with respect to an investment in the PG&E Corporation Stock Fund made at least 3 business days before the dividend record date.

Dividend Election

If you would like to have all of your dividends reinvested, you do not need to do anything. Dividends that are reinvested in additional units of the PG&E Corporation Stock Fund are not taxed until withdrawn.

Dividend Pass Through

If you would like to receive all or a portion of your dividends in cash, you must notify Fidelity Investments at least 10 calendar days before dividends are paid, excluding NYSE holidays. You may specify the portion of dividends to be paid in cash in 1% increments. To make a dividend election, you are required to call Fidelity at **1-877-743-4015**. Each dividend payment is subject to federal and state income taxes in the year in which it is paid; however, no federal or state penalty taxes on early distributions from defined contribution plans will apply.

Voting Rights

If you participate in the PG&E Corporation Stock Fund, you will have the right to vote the proportionate shares of PG&E Corporation common stock held in the Fund that are credited to your account in the Plan as of the proxy record date. The Trustee will send participants the proxy solicitation material issued by the Corporation and a form requesting confidential instructions on how to vote each participant's shares. If you do not direct how to vote your shares, the Trustee will not make any votes with respect to the stock credited to your account.

Monitoring and Making Changes to Your Investments

Because your investment objectives and financial needs change over time, it is important that you have the flexibility and tools to review your account activity and modify your investment periodically.

Fund Transfers and Exchanges

You may log onto NetBenefits℠ at 401k.com or contact Fidelity by calling 1-877-743-4015 to transfer (exchange) money you have accumulated in the Plan among the various Tier 1 and Tier 2 investment fund options offered through the Plan, as well as into the Self-Directed Account (if you have previously established a Fidelity BrokerageLink account). Prior to initiating an exchange, it is recommended that you carefully review the relevant investment fund descriptions to understand the investment fund characteristics and any restrictions on the frequency of exchanges.

Effective January 1, 2019, the company match is made in cash and invested based on your investment elections on file with Plan's service provider, Fidelity Investments. If there are no investment elections on file, the matching employer contributions will be invested in an RSP Target Date Fund that has a target retirement date closest to the year in which you reach age 65. Previously, matching employer contributions were invested in the PG&E Corporation Stock Fund. You may reallocate the employer match that was automatically invested in the PG&E Corporation Stock Fund to the other investment options at any time after it has been credited to your account, subject to the prohibition against insider trading (see "PG&E Corporation Stock Fund Exchanges" for more information).

You are not allowed to make more than one exchange into or out of the funds listed below within the specified restriction period:

Fund	Restriction Period
RSP International Stock Index Fund	30-day restriction

Exchanges among the investment funds may be made on a daily basis, in increments of at least 1% of the value of the source investment fund. Exchanges completed before 4 p.m. Eastern time are effective and valued at the close of the NYSE that day. Exchanges completed after the close of the NYSE, normally 4 p.m. Eastern time, or on

non-business days, will be valued at the closing price on the next NYSE trading day. The amount you are transferring will be credited to your new investment fund choice at the unit (or share value) closing price.

Fund Transfers and Exchanges Involving Self-Directed Account Investments

You cannot make direct exchanges of fund balances invested in any of the funds offered in Tiers 1 and 2 of the Plan to mutual funds available through the Self-Directed Account. Fund balances exchanged from any of the Tier 1 or Tier 2 Core Funds to the Self-Directed Account are deposited as cash into a cash reserve account in the Self-Directed Account. These cash reserve assets can then be used, at your direction, to purchase mutual funds available through the Self-Directed Account. Any fees associated with such transactions are paid from the cash reserve account. Participants wishing to reinvest assets held in the Self-Directed Account into the RSP Tier 1 and/or Tier 2 Core Funds can only make direct exchanges from a Self-Directed Account cash reserve account to the RSP Money Market Fund. Once such assets are exchanged into the RSP Money Market Fund, they can be exchanged into the other funds available under Tiers 1 and Tier 2, subject to the restrictions discussed above.

Most exchanges between Tier 1 and Tier 2 Core Funds and mutual funds within the Self-Directed Account require a three (3) business day settlement period. You may go through NetBenefits or speak to a BrokerageLink representative to exchange from a Self-Directed Account into the RSP Money Market Fund. When placing a sell order in your Self-Directed Account, you must first liquidate mutual fund holdings within BrokerageLink, which settle to the Self-Directed Account cash reserves. Following each settlement, you must go through NetBenefits℠ or call Fidelity back after each settlement to transfer funds from the Self-Directed Account's cash reserve account back to the RSP Money Market Fund. Any trade-related expenses (commissions or other fees) and realized loss or gain will be borne by your Self-Directed Account.

Fidelity will liquidate and transfer assets out of the Self-Directed Account to the extent necessary to correct certain problems, including, for example, assets that have been deposited in the Self-Directed Account via an unauthorized channel. An "unauthorized channel" means in any manner other than through a payroll deduction or the exchange of one Plan investment for another. In the event of a correction, Fidelity will look to the Self-Directed Account's cash reserve account first. If that account does not contain sufficient assets, Fidelity will place sell trade orders with respect to your Self-Directed Account investments. Securities will be sold (liquidated) on a last-in-first-out basis, and will be limited to the number of shares necessary to correct the problem.

Fidelity will transfer assets into the Self-Directed Account to the extent necessary to correct certain problems, including, for example, a negative balance in the Self-Directed Account's cash reserve account due to an unsecured debit or overdraft, or assets that have been withdrawn from the Self-Directed Account via an unauthorized channel. An "unauthorized channel" means in any manner other than through the Plan's recordkeeping system. In the event of an unauthorized channel withdrawal, Fidelity will contact you and request that the withdrawn assets be returned to Fidelity. Upon return, those assets will be re-deposited into the Self-Directed Account's cash reserve account. In the event of an unsecured debit or overdraft, Fidelity will look first to your investments in Tiers 1 and 2. If Tiers 1 and 2 do not contain sufficient assets, Fidelity will place sell trade orders with respect to your Self-Directed Account investments.

Securities will be sold (liquidated) on a last-in-first-out basis, and will be limited to the number of shares necessary to correct the problem.

There may be restrictions or trading fees on some funds in the Self-Directed Account. You will need to contact Fidelity by calling 1-877-743-4015 for more information on restrictions.

With respect to exchanges into the Self-Directed Account, if a request is confirmed before the close of the market (generally 4 p.m. Eastern time on non-holiday weekdays), 100% of the exchanged amount will be available for trading on the next business day. However, if the exchange is initiated through a BrokerageLink representative (i.e., not through NetBenefits℠), 90% of the assets will be immediately available to trade through a BrokerageLink representative.

PG&E Corporation Stock Fund Exchanges

Trades into or out of the PG&E Corporation Stock Fund are permitted. However, if you are aware of "inside" information (i.e., information that would be important to an investor, but which has not yet been made public), you are prohibited by federal securities laws and PG&E Corporation policy from trading in the PG&E Corporation Stock Fund until the information has been publicly disseminated.

Executive officers of PG&E Corporation and members of the Board of Directors of PG&E Corporation are subject to additional restrictions with respect to transactions involving the PG&E Corporation Stock Fund in order to ensure compliance with section 16 of the Securities Exchange Act of 1934.

Fidelity will process requests to sell PG&E Corporation Stock Fund units for exchanges, withdrawals, distributions, and loans provided that there are enough short-term investments in the Fund for liquidity. In the unusual event that there are not enough short-term investments for liquidity, requests to sell units will be suspended. As long as the PG&E Corporation Stock Fund remains open and participants have not canceled the transaction, their requests to sell units will be processed, generally on a first-in-first-out basis, as liquidity is restored in the Fund. Loans and withdrawals will be given priority over exchanges. If a transaction involves a suspended sale of PG&E Corporation Stock Fund units, the entire transaction will be suspended, including the corresponding purchase transaction. Participants will receive the net asset value on the processing date.

Participants who have requested transactions requiring the sale of PG&E Corporation Stock Fund units will need to check their account the following business day to determine whether their request has been processed.

Accessing Your Account

This section describes the rules and process of accessing the funds in your account. Specific information for participants about their individual accounts is available online at Fidelity Investments' website, NetBenefits℠, at 401k.com, or by telephone from Fidelity at **1-877-743-4015**.

Loans

The Plan has a loan feature that gives you access to your money before retirement by letting you borrow from your account at a reasonable rate of interest. You can borrow your money without incurring any immediate income tax liability or early distribution penalties.

If there is a hold on your Plan benefit due to a divorce, you may not be able to take a loan without approval from the QDRO Administrator. Contact the QDRO Department at the PG&E Pension Service Center at **1-800-700-0057**.

As long as you are employed by a participating employer within PG&E Corporation, you are eligible to borrow your money in the Plan. Loans are funded by reducing your Plan balance by the amount you borrow and are secured by a promissory note between you and the Plan Administrator. Repayments, plus interest, are credited back to your account; in essence, you are borrowing the money from yourself.

Please note that if you have any investments in the Self-Directed Account, those investments must be exchanged into one or more of the Plan's Tier 1 or Tier 2 funds before such amounts are available for a loan or loans.

Loan Terms and Borrowing Limits

Loans with a term of five years or less can be used for any reason. Longer-term loans with repayment periods extending up to 15 years may be taken to purchase a principal residence. Interest on long-term loans is not deductible for income tax purposes; therefore, a conventional home mortgage loan may be more advantageous for participants seeking financing for a principal residence.

There are limits to how much you can borrow and how often. You may have only three loans outstanding at any time, and the maximum amount of principal that can be borrowed or outstanding may not exceed the lesser of $50,000 or 50% of the value of your Plan balance invested in Tier 1 and Tier 2 funds, minus the highest outstanding loan balance in the previous 12 months. The minimum loan amount is $1,000. A loan may not be refinanced during the loan term.

A loan may be funded from several types of contributions (before-tax, matching employer, after-tax, etc.) depending on your contribution elections. The proceeds to fund a loan from your Plan balance will be deducted from the various types of contributions invested in Tier 1 and Tier 2 funds in the following sequence:

1. Accumulations attributable to any before-tax contributions
2. Before-tax supplemental contributions
3. Accumulations attributable to any after-tax contributions + earnings

4. Accumulations attributable to matching employer contributions
5. Flex
6. Accumulations attributable to any rollover contributions
7. Accumulations attributable to basic employer contributions**
8. QNEC
9. Accumulations attributable to catch-up contributions
10. After-tax rollovers
11. Accumulations attributable to Roth contributions + earnings
12. Roth catch-up contributions
13. Roth rollovers
14. Roth in-plan conversions
15. RIPC employee contributions

Interest Rates

Interest rates for all loans equal the prime rate plus 1%, as determined by Reuters or any successor selected by the Plan Administrator for the month in which the loan is requested. The rate is set when you apply for a loan and remains fixed throughout the duration of the loan.

Fees

There are fees associated with loans. See "Fees and Expenses" for more information.

However, for Participants performing uniformed military service (as defined under federal law), the interest rate will not be higher than 6%, compounded annually to the extent required by federal law.

Electronic Funds Transfer Service

When you request a loan or withdrawal from your account through Fidelity NetBenefits℠ or Fidelity, you can have the proceeds transferred electronically to your bank account instead of waiting for a check. You can also set up or change your bank account information online or through a Participant Services Representative.

If you will be requesting a loan or withdrawal in the future and would like to take advantage of Electronic Funds Transfer (EFT), you will need to have the service established in advance. The set-up process, known as "pre-note," can be initiated online through NetBenefits℠ online account services (401k.com) or by calling 1-877-743-4015 and speaking with a Participant Services Representative, Monday through Friday, 5 a.m. to 9 p.m. Pacific time. Set-up generally requires seven days to complete. To set up EFT, you'll need to have the following information available:

- Social Security Number
- Personal Identification Number
- Name of Bank Name on Bank Account
- Bank Account Number
- Bank Routing Number

Repayment

Generally, you repay a loan through automatic after-tax payroll deductions. If your current payroll contributions are being invested in Tier 1 and/or Tier 2 funds, loan repayments will be credited back to your account according to your current investment election. If all or any part of your current payroll contributions are being invested in the

Self-Directed Account, the portion of your loan repayments relating to such contributions will be credited to the Self-Directed Account's cash reserve account. Your loan repayments will be credited to the sources in the proportion of which it was taken out.

The maximum repayment term is five years — or up to 15 years if you are using the loan proceeds to purchase a principal residence.

Cash repayments paid in level installments to Fidelity are required if:

- Your net pay is insufficient to cover a payroll deduction for the full amount from your paycheck;
- You are granted an unpaid leave of absence; or
- You terminate employment with PG&E.

You may also make partial or full cash repayment before the completion of the loan term — without prepayment penalties. Following any partial prepayment, the loan can be re-amortized at your direction to provide for continued level installments for the original loan term.

If you terminate employment with Company, you must make direct payments or elect the EFT service to repay any outstanding loan balance to Fidelity Investments. The Plan Administrator reserves the right to call any participant's loan upon a participant's termination of employment with PG&E or upon termination of the Plan.

Loan Repayment Suspensions

For participants on a leave of absence from the Company, loan repayments may be suspended for the lesser of (i) the leave of absence or (ii) 12 months. PG&E will notify Fidelity when a leave of absence is approved for a participant. The participant is responsible for making payments beginning in the 13th month if the leave extends beyond 12 months. Failure to begin repayments in the 13th month will result in a default notification. If a loan remains in default for more than 30 days after notification, the unpaid principal will be treated as a taxable distribution subject to federal and state income tax and applicable penalty taxes.

When you return from a leave of absence, your loan will be reamortized. For more information regarding this reamortization please contact Fidelity's RSP Service Center by calling 1-877-743-4015 for more information.

Suspension of repayment is also allowed during a period when you are performing uniformed military service. Contact Fidelity by calling 1-877-743-4015 for more information.

Loan Defaults and Distributions

A loan is treated as a default whenever a loan payment is not made within 60 days of the date on which it is due. A participant who is late on a loan payment will have 30 days from the date the Plan Administrator provides written notice of the default to cure the default before it becomes final.

If the past due amounts are not paid within the 30-day grace period, any outstanding principal comprised of before-tax contributions (including before-tax catch-up contributions) and earnings that were disbursed with Roth contributions will be treated as a taxable distribution from the Plan. It may also be subject to early distribution tax penalties.

Deemed Distribution of Plan Loans

A loan is considered a deemed distribution when the loan is in default and the participant is not otherwise eligible to receive a distribution of the loan from the Plan. For purposes of a new loan, the loan that was deemed to be distributed will still be treated as outstanding for as long as the participant remains employed by a participating employer within PG&E. This means that both the number of outstanding loans allowed and the allowable total outstanding balance for all loans will be reduced by the number and value of any loan(s) that have been deemed to be distributed. When a participant has a deemed distribution of a loan, the outstanding principal (pre-tax and Roth earnings) and accrued interest is reported to the participant and the IRS on a Form 1099-R.

Plan Loans When Your Plan Balance is Distributed

If you terminate employment and request a distribution of your Plan balance, your outstanding loan balance will be considered a part of this distribution. In other words, the value of your outstanding loan will be reported as a taxable distribution from the Plan to the extent not already taxed.

Funding Process and Recordkeeping

You may apply for a loan by logging on to Fidelity NetBenefits℠ online account services at 401k.com or by calling Fidelity at **1-877-743-4015**. Fidelity will send you the loan application paperwork and process the loan upon receipt of your properly completed application form. Spousal consent is required on the loan application if you are married. The check for the loan proceeds and a Truth-In-Lending Agreement will be issued within three to five business days. Your signature endorsement on the check constitutes your agreement to the terms of the loan. A separate loan account will be established and maintained for each loan, and unpaid loan principal and accrued but unpaid interest on the loan will be reflected for accounting purposes in your loan account.

In-Service Withdrawals

In accordance with Internal Revenue Code (IRC) provisions that govern qualified retirement plans, withdrawals and distributions from the Plan are permitted only as provided below. If you are married, spousal consent is required for any withdrawals, including hardship withdrawals from contribution sources that are subject to special restrictions (see "Hardship Withdrawals" for more information). All withdrawals are subject to federal and state income tax and possibly tax penalties for early distribution (see "Taxes and Penalties"). Additionally, there are fees associated with in-service withdrawals (see "Fees and Expenses" for more information).

Withdrawals from the investment funds, except PG&E Corporation Stock Fund, must be taken in cash unless you elect a direct rollover. A direct rollover is not allowed for hardship withdrawals.

Please note that if you have any investments in the Self-Directed Account, those investments must be exchanged into one or more of the Plan's Tier 1 or Tier 2 funds before such amounts are available for a withdrawal or distribution. However, if there are insufficient assets in Tiers 1 and/or 2 to make any legally required or other necessary distributions (for example, Minimum Required Distributions, discussed below), Fidelity will liquidate investments in your Self-Directed Account and use the assets to make the required distribution.

Source and Sequence of Withdrawals

It is important to realize that when you request a withdrawal, you are requesting that investment units (which are the measure of your interest in the investment funds) be withdrawn and converted to cash to pay for the withdrawal. The source of your withdrawal and the sequence in which it is paid determines the extent to which it is taxable. The Plan Administrator will use the following sequence when making distributions from your account:

1. after-tax contributions made before 1987, plus earnings
2. after-tax contributions made after 1986, plus earnings
3. rollover contributions and earnings
4. matching employer contributions and earnings that have been held in the Plan for at least two years, subject to certain exceptions as discussed below
5. eligible Roth contributions and earnings
6. eligible before-tax contributions and earnings
7. eligible catch-up contributions and earnings

Withdrawal will be allocated proportionally across all funds held at a specific source level. For example, if your after-tax contributions are invested 50% in the PG&E Corporation Stock Fund and 50% in the 2045 Target Date Fund, then 50% of your after-tax withdrawal will be from the PG&E Corporation Stock Fund and 50% from the 2045 Target Date Fund.

After-Tax Contributions

There are no restrictions on withdrawals of after-tax contributions and earnings. You may withdraw your after-tax contributions to the Plan and any earnings thereon at any time. Note that earnings withdrawn are taxable, and also may be subject to early distribution penalty taxes.

Rollover Contributions

You may withdraw money you rolled over to the Plan from another qualified retirement plan from a previous employer, plus earnings, at any time. Any taxable amount of your withdrawal is subject to ordinary income tax and may be subject to early distribution penalty taxes.

Matching Employer Contributions

You may withdraw matching employer contributions (plus earnings) that have been in this Plan for at least two full calendar years. For example, if you want to withdraw income attributable to matching employer contributions made at any time in 2025, you must wait until 2028 or anytime thereafter. Exceptions to the two-year waiting period are granted if you:

- become permanently disabled;
- have attained age 59½; or
- have requested and are entitled to receive a hardship withdrawal (see "Hardship Withdrawals" for more information).

Before-tax and Roth Contributions (Including Catch-Up Contributions)

Withdrawals of your before-tax and Roth contributions to the Plan and any associated earnings are generally restricted while you are employed within PG&E Corporation.

If you are currently employed within PG&E Corporation, you may only withdraw before-tax contributions and Roth contribution and earnings if you:

- become permanently disabled;
- have attained age 59½; or
- are a military reservist ordered or called to active duty for a period in excess of 179 days (or for an indefinite period) after September 11, 2001,; or
- if you are on active military duty for more than 30 days.

If you take a withdrawal of before-tax or Roth contributions and/or earnings while on military duty, you are automatically suspended from Plan participation and may not resume making contributions to the Plan for six months following the date on which the distribution was made. (

Hardship Withdrawals

You may take a hardship withdrawal while you are employed within PG&E Corporation only on account of an immediate and heavy financial need. To be eligible for a hardship withdrawal, you must have exhausted all other financial resources — insurance proceeds, reasonable liquidation of your other financial assets, cessation of your contributions to the Plan, or distribution of dividends from shares held in the PG&E Corporation Stock Fund.,. You will also have to provide satisfactory proof of valid hardship to the Plan Administrator.

If there is a Hold on your Plan benefit due to a divorce, you may not be able to take a hardship withdrawal without approval from the QDRO Administrator. Contact the QDRO Department at the PG&E Pension Service Center at **1-800-700-0057** for approval.

The following reasons will be considered to be valid hardships:

- to cover unreimbursed medical expenses for the participant, spouse, or dependents (as defined in IRC section 152, without regard to section 152(b)(1), (b)(2) and (d)(1)(B)) or primary beneficiary, determined without regard to whether the expenses exceed 7.5% of adjusted gross income;
- the purchase of the participant's principal residence (excluding mortgage payments);
- tuition payments and/or room and board for the next twelve months of post-secondary education for the participant, spouse, dependents, (as defined in IRC section 152) or primary beneficiary;
- payments necessary to prevent foreclosure on the mortgage of, or eviction from, the participant's principal residence;
- to pay expenses for the repair or damage to the participant's or beneficiary's principal residence that would qualify for the casualty deduction under IRC section 165 (determined without regard to whether the loss exceeds 10% of adjusted gross income);
- unreimbursed expenses for the funeral of a participant's parent, spouse, dependent (as defined in IRC section 152) or primary beneficiary;
- taxes or unreimbursed expenses directly related to the participant's bankruptcy; or
- to meet expenses and losses (including loss of income) incurred by the participant on account of a disaster declared by the Federal Emergency Management Agency (FEMA), provided that the participant's principal resident or principal place of employment at the time of the disaster is located in an area designated by FEMA for individual assistance with respect to the disaster.

Amounts available for hardship withdrawals will follow the withdrawal order described under the "Source and Sequence of Withdrawals" heading, above, including your employer contributions and earnings not otherwise available to be distributed, and your before-tax and Roth contributions, including any catch-up contributions plus earnings. Participants requesting a hardship withdrawal may not request an amount that exceeds the amount actually required to satisfy the immediate financial need. The Plan Administrator will automatically withhold 10% for federal taxes from a hardship withdrawal, unless the participant specifies different withholding. Hardship withdrawals may also be subject to early distribution tax penalties.

Additional Withdrawals

You may take a withdrawal while you are employed within PG&E Corporation for the following reasons:

Emergency Personal Expense

You may withdraw up to $1,000 if you experience an unforeseeable or immediate financial need. You may repay the amount within three years of withdrawal. You may make this withdrawal once each calendar year if the full amount of the initial distribution is repaid to the Plan or the amount of your employee deferrals after the initial withdrawal is at least equal to the amount of the initial withdrawal that has not been repaid to the Plan.

Domestic Abuse

You may withdraw up to the lesser of $10,000 (as may be adjusted by the IRS) or 50% of the value of your accounts (in the aggregate) within one year after experiencing domestic abuse by your spouse or domestic partner. You may repay the amount within three years of the withdrawal; you may not make an additional withdrawal until the initial withdrawal has been repaid.

Qualified Birth or Adoption

You may withdraw up to $5,000 of the value of your accounts (in the aggregate) within one year of the birth or adoption (as of the date legally finalized) of your child. You may repay this amount within three years of the withdrawal.

These in-service withdrawals will follow the withdrawal order described under the "Source and Sequence of Withdrawals".

Terminal Illness

If you are eligible to take an in-service distribution and have not terminated employment, you may request that the in-service distribution be characterized as a terminally ill distribution, if you are terminally ill and provide a physician's certificate that your illness is reasonably expected to result in death within 84 months. This characterization excludes the distribution from the 10% tax on early distributions. You may repay the distribution within three years.

Withdrawal Options When You Leave PG&E

When your employment with any and all employers within PG&E ends, the full value of your account is payable to you. Depending on your account balance, you may elect to leave your money in your account until a later date, or you may take a full or partial distribution of your account balance.

A distribution package will be mailed to your home after a 30-day waiting period. The package contains information should you want to withdraw all or a part of your account balance. You may elect to have your distribution transferred to an IRA or other tax-qualified plan, or you may elect to have it paid to you.

If your account balance is $1,000 or less when you retire or leave the employment of the Company, you will receive a letter and a distribution form. You must take a lump-sum distribution of your account balance. If the Plan Administrator does not receive your election form within 60 days from the date on which the materials are mailed to you, your distribution will be sent to you in cash subject to mandatory 20% federal income tax withholding (see "Taxes and Penalties").

If your account balance is greater than $1,000 but not greater than $7,000 when you retire or leave the employment of the Company, you will receive a letter and a distribution form. You must take a lump-sum distribution of your account balance. If the Plan Administrator does not receive your election form within 60 days from the date on which the materials are mailed to you, your distribution will be automatically rolled over to a Fidelity IRA in your name and invested in the Fidelity Cash Reserve Fund, which is an investment designed to preserve capital and provide a reasonable rate of return and liquidity.

If your account balance is greater than $7,000 when you retire or leave the employment of the Company, your account may remain in the Plan until you request a lump-sum or partial distribution of your account balance. Although your money can remain in the Plan, you may not make additional contributions or borrow money from your account. However, as long as you maintain a balance greater than $7,000, you may still make transfers among the investment funds or request partial withdrawals or a distribution from your account. Your account will continue to share in any investment gains or losses for the funds in which you are invested (see "Monitoring and Making Changes to Your Investments"). If you leave employment before retirement age (age 55) and you keep your account in the Plan, your account will be charged a recordkeeping fee on a quarterly basis (see "Fees and Expenses" for more information). If you retire and keep your account in the Plan, PG&E will continue to pay the recordkeeping fee on your behalf.

If your account balance is greater than $7,000 when you retire or your employment ends, you may also choose to have distributions paid in equal monthly, quarterly, or annual installments. Payments can begin immediately or at a later date that is specified by you. Payments can be deposited directly into your bank account.

Distributions After Your Employment Has Ended

If you are retired or have terminated your employment with PG&E and have left your account balance in the Plan, you must take a minimum distribution from the Plan no later than April 1 of the calendar year following the year in which you turn age 73 (72 for a participant who attained age 72 on or after January 1, 2020 and prior to January 1, 2023; 70 ½ for a participant who attained age 70 ½ prior to January 1, 2020), or, if later, the year you retire. Once minimum distributions have started, you must receive a minimum distribution annually. There is a fee imposed each year that a participant receives a minimum required distribution (see "Fees and Expenses" or more information).

Minimum required distributions will be made from your investments in Tiers 1 and 2 of the Plan. However, if there are insufficient assets in Tiers 1 and 2 to make any required distributions and you do not liquidate sufficient funds upon notification of the requirement to do so, Fidelity will liquidate investments in your Self-Directed Account and use the assets to make the required distribution. In such a case, Fidelity will look to the Self-Directed Account's cash reserve account first. If that account does not contain sufficient assets, Fidelity will place sell

trade orders with respect to your Self-Directed Account investments. Securities will be sold (liquidated) on a last-in-first-out basis, and be limited to the number of shares necessary to make the required distribution.

The Plan Administrator will notify you if you are subject to required minimum distributions. The Plan Administrator can perform a default calculation (based on Single Life Expectancy) to determine the amount that will satisfy your minimum required distribution. Alternatively, you may make a one-time election to direct the Plan Administrator to use other assumptions (such as Joint Life Expectancy) in the calculation of your required distribution.

Note that minimum required distributions paid from the Plan satisfy the requirements for this Plan only. If you have money invested in other employer-sponsored pension plans or IRAs, minimum required distribution for those plans or retirement accounts must be satisfied independently of the requirements for this Plan.

Investment and Advisory Services

The Plan offers a range of investment and advisory services to help you become a more informed investor and provide access to expert financial guidance.

These services are provided for informational and educational purposes only. Keep in mind that investing involves risk. The value of your investment will fluctuate over time and you may gain or lose money. Always consider carefully the investment objectives, risk, charges, and expenses of any investment option before investing.

Edelman Financial Engines

Edelman Financial Engines is an unbiased, independent advisory firm which the Plan Administrator has selected to provide Plan participants with support and assistance in making investment decisions. Edelman Financial Engines provides two basic types of assistance.

Online Advice

Edelman Financial Engines' Online Advice service is an internet-based interactive service that can help you:

- Build an investment strategy;
- Get advice on which investments to select in Tiers 1 and/or 2 of the Plan; and
- Monitor your account over time.

You can access Online Advice through Fidelity NetBenefits℠ at 401k.com by selecting the Edelman Financial Engines link. There is no cost to you for using Online Advice since PG&E pays the full cost of this service.

Professional Management

You have the option to enroll in Edelman Financial Engines' Professional Management. If you enroll in Professional Management, you are retaining Edelman Financial Engines as your own investment advisor. There are fees associated with this service (see "Fees and Expenses" for more information).

As your investment advisor, Edelman Financial Engines will:

- Create a retirement savings strategy for your Plan investments;
- Professionally manage your account for you, including directing Fidelity to carry out investment transactions on your behalf; and
- Provide you with quarterly progress reports.

Fees for Professional Management will be deducted quarterly from your Plan account based on the assets in your account that are under professional management. Please read about applicable fees at edelmanfinancialengines.com/forpge.

The specific terms of your relationship with Edelman Financial Engines are set forth in the customer agreement that you enter into directly with Edelman Financial Engines. If you enroll in Professional Management, you may terminate at any time by contacting Edelman Financial Engines.

Professional Management Income+

If you're enrolled in Professional Management, you can take advantage of Fidelity's Income+ service if you're age 60 or within five years from retirement.

- Help with preservation. Get help with managing your account with a goal of balancing growth with safety. Fidelity will provide you with an updated Retirement Plan that shows the adjusted investment strategy for your PG&E account.
- Help with planning. Speak to a Professional Management Income+ Investment Advisor Representative for a Retirement Checkup. Review when you might be able to retire, what sources of income you'll have in retirement, and how much you may be able to spend.
- Help with payouts. At your request, the service can also provide monthly payouts from your PG&E Corporation Retirement Savings Plan account that can last throughout your retirement.

If you enroll in Professional Management, Edelman Financial Engines has responsibility as a fiduciary to you for the advice and management it provides. Neither the Plan Administrator nor the Corporation is responsible for the results or advice provided by Edelman Financial Engines. During the time that you are enrolled in Professional Management, Edelman Financial Engines will make all investment decisions with respect to your account. You will not have the ability to make or implement investment decisions directly until you terminate your relationship with Edelman Financial Engines.

Edelman Financial Engines will only manage investments in Tiers 1 and 2 of the Plan. If you have investments in the Self-Directed Account (Tier 3) at the time you enroll in Professional Management, you may maintain your balance in the Self-Directed Account, but you will be responsible for the investment of these assets. During the time you are enrolled in Professional Management, you will not be permitted to make additional payroll contributions into any mutual funds available through the Self-Directed Account.

For more information about retaining Edelman Financial Engines as your investment advisor, including fees for the Professional Management service, please contact Fidelity by calling 1-877-743-4015, or visit edelmanfinancialengines.com/forpge.

Fidelity Education and Modeling Tools

Fidelity offers a number of education and modeling tools to help you manage your account. You can access:

- Planning tools to help determine if you are on track to meet your retirement and savings goals;
- Articles on timely savings and retirement topics;
- Calculators to help with financial questions, such as the impact of transactions, such as loans and withdrawals.

Learn more about these resources by logging on to Fidelity NetBenefits℠ online account services at 401k.com or by calling Fidelity at **1-877-743-4015**.

Taxes and Penalties

The taxable portion of Plan withdrawals and distributions is generally taxed as ordinary income in the year it is received. Further, withdrawals taken before age 59½ may be subject to nondeductible penalty taxes, unless you qualify for an exemption.

The taxable portion of virtually all non-periodic Plan withdrawals (other than hardship withdrawals) is also subject to mandatory 20% federal withholding tax, unless you arrange to directly roll over the money into an IRA or to another qualified retirement plan.

Certain lump-sum distributions from the Plan may be eligible for special tax treatment if you meet age and participation requirements. If you were born before 1936, you may be eligible for ten-year forward income averaging when you retire if you take a total withdrawal of your account balance. If you think you may be eligible for forward income averaging, you should consult a tax advisor prior to retirement.

Your Plan withdrawals and distributions will be reported annually on Forms 1099-R, which are mailed in January following the year in which the distribution was paid. You are responsible for reporting the taxable amount as income when you file your income tax returns.

When you request a withdrawal or distribution from the Plan, you will receive tax information regarding your income tax liability. You should read this information carefully to understand your payment options and how the manner in which you elect to receive your distribution affects your taxes and tax withholding. If you choose to take a withdrawal or distribution, you are responsible for complying with Internal Revenue Code rules governing distributions from retirement plans and for any tax consequences, and are strongly encouraged to consult a tax advisor. The Plan Administrator is not responsible for advising participants as to the tax consequences of withdrawals or distributions.

Withdrawals of PG&E Corporation Stock

For any withdrawal of contributions and earnings you have invested in the PG&E Corporation Stock Fund, you may have the total amount converted to PG&E Corporation common stock or paid to you in cash. Withdrawals from all of the other investment funds must be taken in cash, unless you elect a direct rollover. If you want to receive PG&E Corporation stock instead of cash from such other funds, you may exchange all or a portion of your money in the other investment funds for units in the PG&E Corporation Stock Fund before taking the withdrawal.

If you withdraw PG&E Corporation stock, you will only be liable for income taxes on the cost basis of each unit. The cost basis is the average purchase price for all the units you own in the Fund. If you sell the withdrawn shares, you will be liable for income taxes on the difference between the cost basis of your units and the sale price. The income will be subject to the capital gains tax rate if you held the shares for at least one year before the sale.

Participants who are considered “affiliates” of PG&E Corporation may generally resell their shares of PG&E Corporation common stock in compliance with the Securities and Exchange Commission Rule 144.

Rollovers

Most taxable and non-taxable withdrawals and distributions from the Plan are eligible for direct rollover to an IRA or other qualified employer retirement plan that accepts rollovers. There are two types of rollovers – direct rollovers and indirect rollovers. A direct rollover is when the check for your Plan balance is payable directly to the receiving IRA or tax-qualified plan. If you choose a direct rollover of the taxable or non-taxable portion of a Plan distribution:

- no taxes will be withheld when the distribution is paid;
- the distribution will not be reported as taxable income; and
- taxes will be deferred until you later withdraw the money from the IRA or recipient qualified employer plan.

An indirect rollover is when the check for your Plan balance is made payable to you, and you then deposit all or a portion of that amount in an IRA or qualified plan. If you request an indirect rollover, the Plan is required by law to withhold 20% of the taxable amount. When you file your income tax return for that year, you must report the total amount of the distribution, including the withheld tax. You will receive a credit for the tax withheld to help offset the income tax you owe for that year. If you take an indirect rollover, you have 60 days from the date that you receive the distribution to roll it over to an IRA, Roth IRA or other qualified plan. Also, if you roll over taxable amounts to a Roth IRA, you will be subject to income tax on those conversions.

Plan distributions that are not eligible for rollover include:

- refunds of automatic enrollment contributions within 90 days of enrollment;
- ESOP dividends;
- loans treated as deemed distributions;

- distributions that are part of a series of substantially equal payments made at least once a year over a period of your lifetime/life expectancy, your and your beneficiary's lifetimes/life expectancies, or 10 years or more;
- minimum required distributions from the Plan;
- hardship withdrawals; and
- refunds of excess contributions.

Roth contributions, Roth rollovers and Roth in-plan conversion contributions can only be rolled over directly to another Roth contribution account in a qualified retirement plan or Roth IRA that accepts Roth rollovers.

Although PG&E Corporation stock may be an eligible rollover distribution from the Plan, some IRAs and qualified retirement plans may not accept rollovers of stock certificates. Before requesting a direct rollover of stock certificates, you must verify with the recipient IRA trustee or plan administrator that the IRA or plan will accept a direct rollover of stock certificates.

Early Distribution Penalties

In addition to being taxed as ordinary income, distributions taken before age 59½ (early distributions) may be subject to nondeductible federal and state penalty taxes (currently a 10% federal and 2½% California state tax; penalty taxes in other states may differ). Early distributions are exempt from the penalty taxes if made for one of the following reasons:

- refunds of automatic enrollment contributions within 90 days of enrollment;
- ESOP dividends;
- after termination of employment during or after the year in which you reach age 55;
- on account of your permanent disability;
- after termination of employment, in a series of substantially equal periodic payments based on your life expectancy, and continuing for at least five years or until age 59½, whichever is later;
- after qualified service as a reservist (those called to active duty for 180 or more days);
- to cover unreimbursed medical expenses for you, your spouse, or dependents in excess of 7.5% of your adjusted gross income;
- to an alternate payee under a Qualified Domestic Relations Order (QDRO) upon dissolution of marriage;
- to roll over to an IRA or other qualified retirement plan either directly or within 60 days of receipt of the distribution; or
- on account of your death.

The early withdrawal penalties also apply to all hardship distributions except for those taken for unreimbursed medical expenses to the extent that they exceed 7.5% of your adjusted gross income.

The Plan Administrator does not withhold or assess any early distribution penalties when a distribution is paid. If you are subject to the early distribution penalties, you are responsible for including the penalties when you file your income tax return.

What Happens

This section provides general information about how your benefits may be affected by certain life events. Where appropriate, it offers tips about things you may want to consider, actions you may want to take and sources where you can find more information.

In this section you can find information about how your RSP benefit is affected and/or actions you may take:

- "If You Are on an Authorized Leave of Absence"
- "If You Leave PG&E or Retire"

- "If You Die"
- "If You Transfer to or from a Union-Represented Classification"
- "If You Are Divorced or Divorcing"
- "If You Get Rehired"

If You Are on an Authorized Leave of Absence

Authorized leaves of absence include, but are not limited to, absences due to:

- illness or injury;
- family leave;
- qualified military service; or
- short-or long-term disability.

Your participation in the Plan continues as long as your authorized leave of absence does not constitute a break in service. You may continue making employee contributions and receiving employer matching contributions on any covered compensation you receive while on authorized leave of absence (e.g., Sick pay, Vacation pay or (for ESC-represented employees only) Wage Continuation Benefit payments during a Short-Term Disability (STD)/Paid Family Leave (PFL) leave of absence. For pay periods during which you receive no covered compensation from PG&E–for example, if you go on an unpaid leave of absence–no employee contributions or employer matching contributions will be applied for the unpaid period of time.

You may apply for an in-service or hardship withdrawal depending on your account assets, and the type of withdrawal (see "Hardship Withdrawals" for more information). You must meet all Plan and Internal Revenue Code requirements for the requested withdrawal. You may not take a distribution other than a withdrawal as described above from the Plan while on an authorized leave of absence.

If you have an outstanding loan, you may need to arrange for a loan repayment suspension, or arrange to make direct payments to Fidelity to repay the loan while you are on leave (see "Repayment," "Loan Repayment Suspensions," and "Loan Defaults and Distributions" for more information). You may not initiate a new loan while on an unpaid leave of absence.

If You Leave PG&E or Retire

If you terminate your employment with PG&E, you may no longer contribute to the Plan, except for contributions made with respect to retroactive wage payments. You may elect full distribution of your account after your employment ends. You may elect to:

- leave assets in the Plan (subject to minimum account distributions and potential ongoing administrative fees);
- rollover your account balance to an IRA or another employer's plan; or
- take a distribution (subject to taxes and penalties).

See the "Withdrawal Options When You Leave PG&E," "Distributions After Your Employment Has Ended," and "Taxes and Penalties" for additional information.

Administrative Fees

If your employment ends before reaching retirement age (age 55), and you elect to maintain your balance in the Plan, your Plan account will be assessed an administrative fee for the maintenance of your account. This administrative fee does not apply to employees or retirees (employees who are age 55 or older when employment ends). See "Fees and Expenses" for more information.

Loans

You may make direct payments or elect EFT service to repay any outstanding loan balance to Fidelity. The loan will default if a loan payment is not made within 60 days of the date on which it is due. Defaulted loans are treated as plan distributions and are subject to ordinary income taxes. Early distribution penalty taxes may also apply. You cannot take out a new loan once your employment with PG&E ends.

If You Die

If you die, your Plan balance is payable to your beneficiary. If you are married at the time of death and did not designate a different beneficiary with the notarized consent of your spouse, your spouse is automatically your beneficiary. If you are single and did not designate a beneficiary, your estate is your beneficiary. Once the Plan is notified, your spouse or beneficiary will receive his or her options for disposition of the account. Your spouse or beneficiary may elect either to take a lump-sum distribution or to roll the Plan balance over directly into an inherited IRA. For the purposes of the Plan, you have a "spouse" if you are legally married under applicable law of a state or foreign jurisdiction, including a same-sex couple. However, in accordance with IRS guidance, a registered domestic partnership, civil union, or other similar formal relationship that is not denominated as a marriage under the law is not treated as being legally married for purposes of the Plan.

Payment to your beneficiary will occur within 60 days of the Plan Administrator's receipt of your beneficiary's payment instructions. If your beneficiary does not provide payment instructions for disposition of the account within 180 days following the Plan Administrator's receipt of notification of your death, the Plan Administrator will automatically withhold 20% from the taxable portion of the distribution for federal taxes and distribute the remainder to your beneficiary in a lump sum (see "Taxes and Penalties").

You may change your beneficiary designation at any time by logging onto NetBenefits℠ at 401k.com or by calling Fidelity at **1-877-743-4015**.

If You Transfer to or from a Union-Represented Classification

If you transfer to or from a union-represented classification and participate in the Final Pay Pension, be aware that your eligible company matching contribution percentage may change. Also, loan repayments may be re-amortized and may change the frequency of your payments. For example, upon transition into a non-union-represented classification, paycheck loan repayments elections may need to be adjusted to accommodate a monthly vs. a bi-weekly pay cycle. You may review your loan repayment elections at any time by logging onto NetBenefits℠ at 401k.com or by calling Fidelity at **1-877-743-4015**.

If You Are Divorced or Divorcing

Once the divorce is finalized, you may want to change your beneficiary designation. If your former spouse was previously listed as your beneficiary (and you have not designated a different beneficiary), your Plan balance will remain payable to your former spouse on your death. You can change your beneficiary designation at any time by logging onto NetBenefits℠ at 401k.com or by calling Fidelity at **1-877-743-4015**.

Under current California law, certain Company-provided employee benefits that you earned while married are community property and can be divided between you and your former spouse. A specific court order, called a Qualified Domestic Relations Order ("QDRO") is required to award a portion of your benefits to your former spouse.

In the event a participant is divorced, ERISA permits the division of the participant's Plan account between the participant and certain other beneficiaries pursuant to a QDRO. The Plan Administrator will determine the qualified status of any domestic relations order for a participant who is divorced or legally separated. The Plan will also oversee the disbursement of Plan assets to the participant and the spouse, former spouse, child, or other dependent named in a QDRO as having a right to receive benefits in the Plan.

Domestic relations orders include any judgment, decree, or order (including approval of a property settlement agreement) that relates to child support, alimony payments, or marital property rights and that is made pursuant to state domestic relations laws (including community property law).

If your former spouse has a community property interest in your Retirement Savings Plan account, then a QDRO must be prepared and submitted to the QDRO Department at the PG&E Pension Service Center for review and implementation. If you have questions about the QDRO process or for a sample QDRO and QDRO procedures, please contact the QDRO Department at the PG&E Pension Service Center at **1-800-700-0057**. If a party to your divorce submits written notice of your former spouse being awarded an interest in your Plan benefit (e.g., a joinder, dissolution, marital settlement agreement, draft or proposed QDRO etc.), then a Hold will be placed on your benefit, restricting you from taking withdrawals and distributions from your account until a QDRO is approved and implemented, or a court-filed order awarding your entire benefit to you is submitted to the QDRO Department at the PG&E Pension Service Center.

If You Get Rehired

If you leave the employment of PG&E after completing one year of service and are subsequently rehired, you will receive credit for your past service, and the matching employer contribution will be based on your total years of service at the time you are rehired.

If you leave PG&E before completing one year of service and you return within 12 months, you will receive credit for your past service toward the one-year service requirement for matching employer contributions. If you leave PG&E before completing one year of service and you are gone for 12 months or more, you must work for 12 months before you are eligible for matching employer contributions.

If you are rehired on or after January 1, 2013 have a break of service of 12 months or more, and have one or more years of service, you will be automatically enrolled in the Plan and will receive matching employer contributions of $0.75 per dollar on each dollar you contribute, up to 8% of pay. See “Matching Employer Contributions” and “Automatic Enrollment in the Plan” for more information.

Additional Plan Information

This section describes a number of regulations that apply to the benefits described in this Handbook, and provides some administrative details about the plans. For further information on these and other rules, see *Rules, Regulations & Administrative Information*.

Significant Accounting Policies and Investment Disclosure

Participants’ contributions to the investment funds offered under the Plan are credited to participants’ accounts as “units,” rather than individual purchases of stocks, bonds, or other securities. The gains or losses in investment fund values are accounted for through increases or decreases in the value of the units. Similar to mutual fund share prices, unit values change daily, taking into account the current fair market value of the investment portfolio, including any earned interest or dividend income, and are determined by dividing the net assets of the fund by the number of units outstanding.

Fees and Expenses

Participants who are no longer employed at PG&E but who continue to have a balance in the Plan are assessed an administrative fee for as long as they keep an account in the Plan. The fee will be deducted from your account at the beginning of each quarter and will be reflected on your quarterly statement. This fee applies only to employees who terminate their employment at PG&E before age 55 and decide to maintain their Plan account. It will not apply to PG&E employees or retirees (employees who were age 55 or older at employment termination). For fees and expenses details, visit 401k.com and navigate to Plan Information and the Required Disclosure Information document.

If you have an account in the Plan, and you select or execute the following service(s) or transaction(s), the fee(s) outlined below are deducted from your account. As you review this information, please keep in mind that fees are subject to change and that certain individual fees may not be deducted in some circumstances.

Type of Fee	Amount
Loan Setup Fee	$50.00 per loan
Prior Loan Maintenance Fee	$15.00 per year per loan initiated prior to 11/01/2009, deducted quarterly.
Loan Maintenance Fee	$25.00 per year per loan initiated on or after 11/09/2009, deducted quarterly
In-Service Withdrawal Fee	$0 per transaction
Minimum Required Distribution Fee	$0 per distribution year
Overnight Mailing Fee	$25.00 per transaction
Edelman Financial Engines Professional Management Fee	If you utilize this service, the Edelman Financial Engines fee is as follows: 0.50% per year for the first $100,000.00 in your account; 0.45% per year on the next $100,000.01 to $250,000.00; 0.30% per year for any amount over $250,000.00 and is deducted quarterly.

Investment management and trust expenses are netted against investment returns of Tier 1 and Tier 2 funds. Mutual fund fees and expenses are netted against investment returns for mutual funds in Tier 3. Administrative costs (with the exception of loan fees and Edelman Financial Engines' Professional Management fees) are generally paid by PG&E Corporation or participating employers, however, the Plan Administrator will use Plan assets that have been forfeited and are not allocable to individual accounts to pay the reasonable, administrative expenses of the Plan. Additional fee and expense information is provided in the Participant Disclosure Notice that is provided to you each year.

The fund descriptions and more information on fees and expenses can be found on Fidelity NetBenefits℠ at or by calling Fidelity at 1-877-743-4015. The automated voice response system is available 24 hours a day. You can speak with a Participant Services Representative Monday through Friday from 5 a.m. to 9 p.m. Pacific time.

Plan Administration and the Corporation's Power and Duties

The PG&E Corporation Employee Benefit Committee is the Plan Administrator and is responsible for the overall administration of the Plan. This committee has the sole power and discretionary authority to establish, and from time-to-time revise, such rules and regulations as may be necessary to administer the Plan in a nondiscriminatory manner for the exclusive benefit of participants and all other persons entitled to benefits under the Plan. This committee delegates to the Senior Vice President – Human Resources of PG&E Corporation and assigned staff the authority to interpret, implement, and revise rules and regulations as necessary to administer the Plan in a proper and nondiscriminatory manner. Staff is also responsible for overseeing participant recordkeeping, accounting, reporting, and receipt and disbursement of Plan assets.

The Plan Administrator has the discretionary authority to interpret and construe the terms of the Plan, to resolve any conflicts or discrepancies between documents and to establish rules which are necessary or desirable for the administration of the Plan.

Additionally, on January 11, 2019, the PG&E Corporation Employee Benefit Committee engaged Gallagher Fiduciary Advisors, LLC ("Gallagher") to assume fiduciary responsibility for the PG&E Corporation Stock Fund ("Stock Fund") as an investment option within the 401(k) Plan.

As an independent third-party fiduciary, Gallagher has the full authority to make any and all decisions about the Stock Fund, including whether to continue to permit further participant investment in the Stock Fund.

Participant Account Activity and Plan Service Provider

Individual accounts are maintained for each participant's interest in the Plan and all contributions are accounted for separately with respect to units attributable to before-tax contributions, after-tax contributions, matching employer contributions, catch-up contributions, and any rollover contributions. As previously stated, separate accounts are also maintained for participants with an outstanding Plan loan balance.

Quarterly statements of account activity, reflecting contributions and earnings/losses in each investment fund and summarizing transactions during the period, are mailed to each participant as soon as practicable after the end of each quarter. You may also request to receive quarterly statements online.

Fidelity is the administrative service provider for the Plan, and is charged with day-to-day recordkeeping and participant account maintenance. Participant accounts are valued daily with up-to-date account values and share prices, and transactions may be initiated on a daily basis.

Participant services include:

- 24-hour Internet access through Fidelity NetBenefits℠ online account services (401k.com).
- 24-hour telephone automated voice response system; and
- Participant Services Representatives who are available from 5 a.m. to 9 p.m. Pacific time, 6 a.m. to 10 p.m. Mountain time, 7 a.m. to 11 p.m. Central time, and 8 a.m. to midnight Eastern time at Fidelity at 1-877-743-4015.

Claims and Appeals Procedures

If you have a claim for benefits that cannot be resolved through Fidelity, you may file a claim for benefits in writing with the Plan Administrator. Claims should be submitted to:

The Retirement Savings Plan Administrator
Employee Benefit Committee of PG&E Corporation
300 Lakeside Drive, Suite 210
Oakland, CA 94612

If a claim by a participant or beneficiary is denied in whole or in part, the Plan Administrator will notify the claimant in writing, explaining the reason for denial within 90 days of receipt of the initial claim unless, due to special circumstances, an additional 90 days is required. Such notification will set forth:

- the specific reason for the denial;
- the Plan provision on which the denial is based; and, if necessary,
- any explanation or information that may be beneficial to the claimant in order to perfect the claim.

The notice will also include instructions about how to appeal the Plan Administrator's denial and request that the claim be reviewed, including a statement of your right to bring a civil action under ERISA section 502(c) following an adverse benefit determination on appeal. If you do not receive a notice of denial of your initial claim, you may submit a written request for review to the Plan Administrator within these time periods.

A claimant's appeal for review must be made in writing within 90 days of receiving the Plan Administrator's notice of denial. As part of your appeal, you will (1) have the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits; and (2) be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relating to your claim for benefits. The review of your claim will take into account all comments, documents, records, and other information you submit relating to your claim, without regard to whether it was submitted or considered in the initial benefit determination. Failure to raise issues or present evidence on review will preclude those issues or evidence from being presented in any subsequent proceeding or judicial review of the claim.

A final written decision will be rendered within 60 days of receipt of the appeal for review unless, due to special circumstances, an additional 60 days is required. Your claim is considered approved only if the Plan Administrator's approval is communicated to you in writing.

A participant who is a member of a bargaining unit under any collective bargaining agreement between the Company and any union may use the grievance or adjustment procedure of the appropriate collective bargaining agreement to resolve any dispute concerning any question of service, status or membership under the Plan instead of the appeals procedures described above.

The administrative remedies described in this section (as well as a grievance or adjustment procedure of the appropriate collective bargaining agreement if it is used instead of the appeal rights described above) must be exhausted before any legal action can be taken by a claimant. If a claimant timely exhausts all levels of appeal available to the claimant under the Plan's claims procedures (including appeals to both the Plan Administrator and the EBAC), any permissible legal action under ERISA section 502(a) must be initiated before the end of the earliest of:

(1) one year from the date of the Employee Benefit Appeals Committee's ("EBAC") denial of a claimant's appeal of a denied claim for benefits under the claims procedures;

(2) one year from the latest date on which an appeal is permitted to be filed with the EBAC under the claims procedures (i.e., within 60 days of receipt of notice of the denial of a claim); or

(3) two years from the date the claimant knew or should have known that a claim existed.

Claimants must file suit in the Federal District Court for the Northern District of California. The review procedures described in this section are the exclusive administrative procedures provided under the Plan.

Borrowing, Pledging, and Assigning Interests in the Plan

No participant or beneficiary may borrow against, pledge, or assign — voluntarily or involuntarily, or by operation of law — any interest in the Plan or in any distribution to be made under the Plan. However, this does not prevent an employee from obtaining a loan from his or her Plan account in accordance with the Plan's loan procedures. Also, a spouse, former spouse, child, or other dependent of an employee may be able to claim an interest in an employee's Plan benefits under a QDRO issued by a court. If a participant files for personal bankruptcy, an exclusion and certain exceptions under the bankruptcy law may be applicable to part or all of the participant's Plan account.

Except as described above, no party, including creditors of PG&E Corporation, has or may create a lien on any funds, securities, or other assets held under the Plan.

Future of the Plan

Although the Corporation expects the Plan to continue indefinitely, it has the exclusive right to amend, suspend, or terminate the Plan at any time. No amendment to the Plan may be made, however, that would result in a participant's or beneficiary's loss of rights or accumulated Plan assets. Further, in the event of Plan termination, all contributions to the Plan will stop, but the Plan will continue to operate until all of the assets have been distributed in accordance with Plan provisions in effect on the date of its termination.

Fidelity's RSP Service Center Facility of Payment

If you are entitled to any payment under the Plan, and the Plan Administrator determines that you are physically or mentally incompetent and no guardian or conservator has been appointed to receive your payment, the Plan Administrator may make payments on your behalf to a third-party to be applied for and on behalf of and for your benefit. Payments made on your behalf will completely discharge the Plan's responsibility for the amount of the payment.

No Guarantee of Employment

Participation in the Plan does not guarantee your right to employment with PG&E Corporation or any affiliates. Further, nothing set forth in this Summary of Benefits Handbook should be interpreted to give you or your beneficiary any legal or equitable rights against PG&E or its affiliates.

Military Service

Federal law provides rights to certain reemployed veterans for service credit and makeup contributions for all or a portion of the period of military service. Please contact Fidelity's RSP Service Center at **1-877-743-4015** for more information.

Missing Participants

If the Plan Administrator is unable to locate a Participant after three years and after reasonable efforts have been made to do so, the Participant's benefit under the Plan will be forfeited and applied to the Plan's reasonable administrative expenses. If a proper claim is subsequently presented, the Participant's benefit will be reinstated.

Requests for Documents

Participants may review the Plan document, the Trust Agreement between the Corporation and Fidelity Management Trust Company, Investment Agreements between the Corporation and the investment managers, and the Summary Plan Description and any amendments or changes to the provisions contained in these documents at the office of the Plan Administrator. Any report regarding the Plan filed with the Department of Labor, the Internal Revenue Service, or any other governmental agency is also available for review. Requests for copies of any of these documents must be made to the Plan Administrator as follows:

Employee Benefit Committee of PG&E Corporation
Benefits Department
300 Lakeside Drive, Suite 210
Oakland, CA 94612

The Plan Administrator reserves the right to charge for providing such copies, up to the amount permitted under ERISA.

Copies of PG&E Corporation's latest annual report to shareholders, proxy statement, reports, and other communications sent to shareholders, are available without charge upon oral or written request to the Plan Administrator. Requests may be directed to:

PG&E Corporation
Corporate Secretary
300 Lakeside Drive
Oakland, CA 94612

Retiree Health and Welfare Benefits

Your employee health benefit coverage will end on the last day of the month in which you terminate your employment. Upon retirement, you may choose to continue medical coverage under the PG&E Retiree Medical Plan if you meet the eligibility requirements. In general, the dependents you cover as an employee will also continue to be eligible to be covered under your retiree plan, unless they otherwise lose eligibility.

In addition, you are eligible for Postretirement Life Insurance coverage if you retire under the Company's Retirement Plan at age 55 or later. You do not need to enroll for coverage. Coverage is automatic if you meet the eligibility requirements. The Company pays the full cost for your coverage.

For more information, you can access a copy of the Summary of Benefits Handbook for Retirees and Surviving Dependents online at mypgebenefits.com. You can also request the handbook by calling the PG&E Benefits Service Center at **1-866-271-8144**.

Time Off and Leaves

Each year, you are able to accrue paid vacation. In addition, the Company observes 11 paid holidays, and you receive three floating holidays. For information about sick leave and disability policies, please refer to *Leave and Disability*.

Other types of time off policies are also described in this section, including time off for:

- Leaves of Absence
- Jury Duty
- Funerals
- Adoption
- Voting
- Family School Partnership Act (FSPA) and School Suspension Leave
- California Protections for Victims of Violence and Family Members of Victims
- Civil Air Patrol Leave
- Emergency Duty Leave and Volunteer Firefighter Training
- Berkeley Family Friendly and Environment Friendly Workplace Ordinance (BFFEFWO)
- San Francisco Family Friendly Workplace Ordinance (SF FFWO)

Who's Not Eligible

You are not entitled to Time Off benefits, as described in this section, if you are a contract or agency worker, a hiring hall employee, or a retiree. Hiring Hall employees may be entitled to time off under the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), or other state statutes if they meet the criteria described under "Leaves of Absence." For additional information, please refer to *Leave and Disability*.

The benefits described in this "Time Off and Leaves" section are not subject to ERISA.

Additional Information

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

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Vacation Program

The Vacation Program described in this section applies to employees of the Company and its subsidiary and affiliated companies that participate in the Vacation program.

Accruing Vacation

As an IBEW-, SEIU- or ESC-represented employee, you begin accruing vacation upon your first day of work; new employees become eligible to take vacation upon attaining regular status. All references in this "Accruing Vacation" section that pertain to Short-Term Disability (STD) and Paid Family Leave (PFL) are applicable to ESC-represented employees only. The amount of vacation you accrue is based on your length of service with the Company. Upon hire, IBEW- and SEIU-represented employees are eligible to accrue vacation up to 80 hours per calendar year. Effective January 1, 2017, upon hire, ESC-represented employees are eligible to accrue vacation up to 120 hours per calendar year. Regardless of the month in which you are hired, you will begin accruing vacation at the time of hire. Your accrual for the first year of employment is prorated based on your hire date.

You accrue vacation time each pay period. The vacation accrued in a pay period is calculated by multiplying your paid straight time hours by the appropriate vacation accrual rate for your years of service. All paid and unpaid straight-time hours, as described below, qualify for vacation accrual.

Paid straight time (as defined here) includes, but is not limited to, vacation, sick time and family sick time, paid holidays, training, jury duty, funeral leave, rest periods and time off with permission with pay.

Workers' Compensation of less than 880 cumulative hours for full-time employees in a calendar year, unpaid leaves of absence of less than 240 cumulative hours for full-time employees in a calendar year, and Short-Term Disability (STD) or Paid Family Leave (PFL) leaves of absence of less than 480 cumulative hours in a calendar year (for ESC-represented employees only). Once you've reached 240 hours of unpaid absence (prorated proportionately for part-time employees), 880 hours for Workers' Compensation absence, or 480 hours of STD or PFL absence (prorated proportionately for part-time employees), you do not start accruing vacation hours again until you return to active work. This accrual period runs concurrently with all leave types and does not restart by moving between STD, PFL, Workers' Compensation or Unpaid Leave statuses. The accrual period during STD, PFL and Workers' Compensation does not restart by crossing over into the following calendar year.

Part-time employees should refer to their bargaining agreement for information on vacation accrual.

For IBEW- and SEIU-represented employees, your accrual rate increases each January 1 of your 5th, 15th, 21st, and 29th anniversary year of employment, as shown in the following table. For ESC-represented employees, your accrual rate increases each January 1 of your 9th, 19th and 29th anniversary year of employment, as shown in the following table.

For example:

If you are an ESC-represented employee and your 9th anniversary is attained at any time during the year, your accrual rate beginning January 1 of that year will be at the 9–18 years of service level, which is 160 hours per year.

If you are an IBEW- or SEIU-represented employee and your 5th anniversary is attained at any time during the year, your accrual rate beginning January 1 of that year will be at the 5–14 years of service level, which is 120 hours per year.

Accrued Annual Vacation		
If your service anniversary year is	**Number of Vacation Days (Hours) You Accrue**	**Total Maximum Vacation Allowance**
Up to 1 Year	For IBEW and SEIU: 1 – 10 days (0 to 80 hours) For ESC: 1 - 15 days (0 - 120 hours)	N/A
IBEW & SEIU ONLY 1–4 Years	10 days / 80 hours	20 days / 160 hours
IBEW & SEIU: 5–14 Years, *ESC: 1–8 Years*	15 days / 120 hours	30 days / 240 hours
IBEW & SEIU: 15–20 Years, *ESC: 9–18 Years*	20 days / 160 hours	40 days / 320 hours
IBEW & SEIU: 21–28 Years, *ESC: 19–28 Years*	25 days / 200 hours	50 days / 400 hours
29 or more Years	30 days / 240 hours	60 days / 480 hours

Accrued vacation hours are shown as whole hours on each pay statement. If you accrue a fractional hour in a pay period, then the fractional hour carries over to the next pay period until one full hour is accrued, at which point it will be reflected on your next pay statement.

Transfers to or from an IBEW- or SEIU-Represented Position

If you transfer from a Management or Administrative & Technical or ESC represented position to a IBEW- or SEIU-represented position during the year, at the time of transfer you will begin accruing vacation at the accrual rate for an IBEW- or SEIU-represented position (see the "Accrued Annual Vacation" chart under "Accruing Vacation").

If you return to a Management, Administrative & Technical or ESC-represented position during the year, you will begin accruing vacation equal to the accrual rate for your Management or Administrative & Technical or ESC-represented position at the time of transfer.

Transfers to or from an ESC-represented Position to a Management or A&T Position

ESC-represented and Management or Administrative & Technical (A&T) positions have the same vacation accrual schedule, so there is no change to your accrual rate.

Transfers from a Paid-Time Off (PTO) Program to a Vacation Program

If you transfer from the PTO Program offered to employees of PG&E Corporation or PG&E Corporation Support Services II, Inc. to the vacation program offered to Company employees, you will begin accruing vacation at the time of transfer at the accrual rate for the Company's vacation program described in this section. Your years of service recognized by the PTO program also will be recognized in determining vacation accruals provided you transfer directly between the companies with no break in service. Any unused PTO will be transferred and converted to vacation, and unused floating holiday and paid holiday balances will be transferred in-kind.

Effects of Absence on Vacation Accrual

Vacation accrues based on paid straight-time hours worked and unpaid straight time, as described below. Paid straight time includes most hours of paid leave such as paid sick time, family sick time, vacation, paid holidays, floating holidays, training, etc. unpaid straight time that qualifies for vacation accrual includes Workers' Compensation of less than 880 cumulative hours in a calendar year for full-time employees, unpaid leaves of absence of less than 240 cumulative hours for full-time employees in a calendar year, and for ESC-represented employees, Short-Term Disability (STD) and Paid Family Leave (PFL) leaves of absence of less than 480

cumulative hours in a calendar year starting on the first day the employee is absent from work (which includes the absences recorded as Capped Sick time, if applicable).

Vacation does not accrue for absences due to:

- Unpaid leave of absence of 240 cumulative hours or more (prorated for part-time employees) in a calendar year;
- STD or PFL leave of absence of 480 cumulative hours or more (prorated for part-time employees) in a calendar year (applies to ESC-represented employees only);
- Layoff;
- Long-Term Disability; or
- Workers' Compensation of 880 cumulative hours or more in a calendar year.

Part-time employees should refer to their bargaining agreement for information on how absence affects vacation accrual.

Employees on Alternate Work Schedules

If you work an alternate work schedule (9/80 or 4/10), your used vacation is recorded and charged against your vacation accrual according to your regularly scheduled workweek. For example, if an employee on a 4/10 work schedule takes vacation on a scheduled workday, 10 hours of vacation will be recorded for that day.

Illness While on Vacation

If you should become sick or disabled while on vacation, you may request, as soon as practicable, that your vacation be changed to sick pay for those days you were sick. However, you must submit satisfactory medical evidence to your supervisor within 15 calendar days of your request. Qualifying reasons for requesting the change would be if you were hospitalized for one or more days or were ordered to bed rest by your doctor for two or more days.

If your illness or disability is covered under any of the leave of absence or short-term disability provisions, a leave of absence must be initiated for job protection through the Company's Leave and Disability Administrator, and a valid medical certification must be submitted for approval. You can reach the **Company's Leave and Disability Administrator at 1-855-732-8217**.

Service Anniversary Days

IBEW- and SEIU-represented employees: You receive an additional five service anniversary days (40 hours) in the year in which you complete five years of service and in each fifth calendar year thereafter. ESC-represented employees: You receive an additional five service anniversary days (40 hours) in the year in which you complete 25 years of service and in each fifth calendar year thereafter.

To qualify for service anniversary days, you must:

- Be on the active payroll (including paid sick leave, vacation, Workers' Compensation of less than 880 cumulative hours in a calendar year, leave of absence with pay,
- Not be receiving benefits under the Company's Long-Term Disability plan, and
- Work in the year that service anniversary days are awarded.

Your service anniversary days will be available to you in the year in which you meet the service requirements provided you have worked one day in that year.

If you terminate prior to the year in which you would have received service anniversary days, you are not eligible for cash payment of prorated service anniversary days.

Service anniversary days affect your maximum vacation allowance because they are used first. If you are at your maximum allowance, then accruals will stop until service anniversary days are exhausted, and your vacation allowance drops below the maximum.

Any service anniversary days not used in the calendar year in which they are awarded will be deferred to the next year.

Part-Time and Intermittent Employees

Union-represented intermittent employees are not eligible for service anniversary vacation. If you are a part-time employee, refer to your particular bargaining agreement for provisions regarding eligibility for service anniversary vacation.

How to Schedule or Defer Your Vacation

Scheduling Your Vacation

Please refer to your particular bargaining agreement for provisions regarding scheduling vacation.

Also, when you take vacation, service anniversary and sick leave bonus vacation days will be deducted first (if applicable) followed by current and deferred vacation.

Deferring Your Vacation

You are encouraged to take vacation each year in order to maintain your physical and emotional health.

Service anniversary days (See "Service Anniversary Days") count towards the maximum vacation allowance in the year awarded.

To avoid a payout of your vacation, you should make sure that current and deferred vacation will not exceed your total maximum vacation allowance.

Work In-Lieu of Vacation

If you are requested to forego any part of your vacation, the Company will pay for the time worked and, in addition, will pay a vacation pay allowance, provided, however, that in no event will you be permitted at your option to forego vacation for the purpose of receiving vacation pay allowance in addition to pay for time worked. Time worked in-lieu of time off for vacation will not be considered overtime as such but will be compensated at the rates of pay applicable to the work performed.

Excess Vacation Payout

If your vacation balance exceeds the maximum vacation allowance, a one-time annual payout will be made in February of each year for excess vacation as of December 31 of the prior year. The excess vacation payout will be calculated using your base rate of pay, less tax withholdings.

For ESC-represented Employees: It is the employee's responsibility to schedule and use excess vacation. Excess vacation may not be paid out should the employee choose not to schedule and use excess vacation time prior to December 31 of the prior year. In this case, excess vacation will be forfeited.

Voluntary Vacation Transfer

PG&E union-represented employees who are on regular payroll may sell vacation pursuant to a local Letter of Agreement and transfer the proceeds to another PG&E employee experiencing a medical emergency, or as otherwise agreed in a Letter of Agreement. Refer to the applicable collective bargaining agreement for additional information regarding this benefit.

Per Letter Agreement 95-105-PGE, IBEW Local 1245, represented employees who are on Workers' Compensation or medical leave of absence AND who have elected to go into outside rehabilitation or onto Long-Term Disability, may sell vacation to alleviate their own financial hardship. This is the only case not requiring a local Letter of Agreement.

Vacation Sale for Medical Emergency policy can be found as an attachment, or via PG&E@Work For Me > About Me > My Time > My Vacation Sale (upper right corner of page).

You are responsible for the taxes on a voluntary vacation transfer. The donor will not receive a check but will receive a letter of explanation and a receipt showing the gross amount of his/her vacation donation and taxes. The net amount of the check will be transferred to the recipient. The recipient will receive a single check payable to him/her for the combined amount of all the vacation donations. Refer to the Vacation section of your bargaining agreement for more details on Voluntary Vacation Transfer rules.

Vacation Pay Upon Termination

If you terminate employment with the Company (including resignation, retirement or death) or are laid off, you will be paid any earned but unused vacation including any deferred or service anniversary days.

Vacation pay is computed at the base rate of pay applicable to your regular position at the time you terminate. For vacation payout purposes, fractional hours will be rounded to the next highest full hour.

Re-Employment with the Company

If you terminate and are later re-employed, you do not receive vacation credit for prior service. Vacation accruals restart at 0-1 or up to 1 year.

Employees who have been laid off and who are later re-employed may receive vacation credit for prior service, depending upon the length of absence. Refer to the Vacation section of your bargaining agreement for applicable rules.

Transfers between PG&E Corporation and Pacific Gas and Electric Company

If you transfer from Pacific Gas and Electric Company to PG&E Corporation, your years of service will be recognized in determining your annual PTO accrual rate. When you transfer, floating holiday and in-lieu holiday balances will be transferred in-kind, and vacation balances will be converted to PTO. If you are a Management, Administrative & Technical, or ESC-Represented employee and transfer to PG&E Corporation after January 1, 2017, your available Incidental and Capped Sick Time will be converted to a "Frozen Sick Leave" Bank. Your unused sick leave balances will be transferred to a Frozen Sick Leave Bank for your use under certain circumstances.

If you transfer from PG&E Corporation to Pacific Gas and Electric Company, your years of service will be recognized in determining your annual vacation rate. Any unused PTO will be transferred and converted to vacation, and unused floating holiday and in-lieu holiday balances will be transferred in-kind. If you have a Frozen Sick Leave Bank and transfer to a Management, Administrative & Technical, or ESC-represented position after January 1, 2017, your "Frozen Sick Leave" Bank will be converted to a Capped Sick Time Bank, and you will start accruing monthly Incidental Sick Time at the time of conversion, in accordance with the Incidental Sick Time policy. If you transfer to an IBEW- or SEIU-Represented position and you have a Frozen Sick Leave Bank, the balance will be transferred and converted to Sick Leave. If you do not have a Frozen Sick Leave Bank, you will be credited with 80 hours of Sick Leave on your date of transfer.

Paid Holidays

As a full-time employee, you are eligible to receive eight hours of holiday pay after completing six months of employment and attaining regular status. In general, once you are eligible, you must be on a "paid" status to be eligible for holiday pay (for example, actively working or on sick leave, vacation, or time off with permission, with pay before and/or after the holiday).

The Company recognizes 11 public holidays and 24 hours of floating holidays a year with pay. The 11 recognized public holidays are:

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation.

New Year's Day	January 1
Martin Luther King, Jr. Day	Third Monday in January
Presidents' Day	Third Monday in February
Memorial Day	Last Monday in May
Juneteenth	June 19
Independence Day	July 4
Labor Day	First Monday in September
Veterans' Day	November 11
Thanksgiving Day	Fourth Thursday in November
Friday after Thanksgiving	Friday after Thanksgiving
Christmas Day	December 25

Regular-status part-time employees are eligible to receive prorated Paid Holidays based on their work schedule. Intermittent employees who are regularly scheduled to work on a Company holiday are eligible to receive pay for the number of hours they are scheduled to work on that day (unless the employee is off work without permission). The three floating holidays are to be used on days on which employees are scheduled to work.

Please refer to the Alternative Work Schedule Standard for additional details on Company Holidays for employees on alternate work schedules.

When a Holiday Falls on a Weekend or Non-Workday

When a holiday falls on a Sunday, it is generally observed on the following Monday.

Part-time employees, please refer to your particular collective bargaining agreement for provisions regarding scheduling vacation.

If a holiday falls on a regular employee's non-workday other than Sunday, full-time employees will be allocated eight paid holiday hours on the day of the non-working day other than Sunday. Such day shall be scheduled in conjunction with the employee's next scheduled vacation except that such day may be taken prior to the employee's next scheduled vacation with the approval of the supervisor in charge. In no event shall the additional day be taken prior to the date of the holiday. Part-time employees will receive a prorated Paid Holiday based on their work schedule.

Intermittent employees will receive pay for non-workday holidays only if they are regularly scheduled to work on that day. The amount of payment an employee receives is equal to what the employee would have earned on that day had it not been a holiday.

Work Performed on a Holiday

If you are required to work on a holiday (regardless of whether it is on a normal workday or regular day off), you will receive overtime for the hours worked and holiday pay. You may request* to have the paid holiday hours remain in your paid holiday account for later use rather than receive holiday pay.

The following explains holiday pay treatment:

Workday	Pay
You do not work	You receive holiday pay.
You work during regular work hours	You receive overtime for hours worked and holiday pay*
You work outside of regularly scheduled hours	You receive overtime for hours worked and holiday pay.
Non-Workday	**Pay**
You do not work	You receive 8 paid holiday hours in paid holiday account.
You work	You receive overtime for hours worked and holiday pay*.

* Rather than receive holiday pay, you may complete the Holiday Option form to have the holiday hours remain in your paid holiday account for later use.

ESC-Represented Employees: Holidays During a Period of Short-Term Disability (STD) or Paid Family Leave (PFL)

Regular full-time are eligible to receive eight holiday hours in their holiday account for each holiday that occurs during the first 480 cumulative hours of an STD (which includes any absences recorded as Capped Sick Time, if applicable) and/or PFL leave in a calendar year.

- In no event shall a regular full-time employee receive holiday hours in their holiday account for holidays that occur during absences beyond 480 cumulative hours of STD and/or PFL leave in a calendar year.
- Regular part-time employees are eligible to receive pro-rated holiday hours in their holiday account for each holiday that occurs on a regular workday during the first 12 weeks of a STD and/or PFL leave in a calendar year, which includes any absences recorded as Capped Sick Time, if applicable.
- In no event shall a regular part-time employee receive holiday hours in their holiday account for holidays that occur during absences beyond 12 weeks of STD or PFL leave in a calendar year.
- This accrual period does not restart by moving between leave statuses or crossing into the following calendar year.

Floating Holidays

You will automatically be allocated 24 hours of Floating Holiday time on January 1 of each year in which you have worked and attained regular status (including years in which you are not actively at work but receiving pay while on sick leave, vacation, or Workers' Compensation for less than 880 cumulative hours in a calendar year, unpaid leave of absence of less than 240 hours in a calendar year, or a paid leave of absence). Employees shall be awarded 24 hours of floating holiday time on their first day worked in the calendar year in which they return to work from approved STD, PFL, or LTD leaves after January 1 of that year. STD leaves are available only to ESC-represented employees.

Unused Floating Holiday Pay Upon Termination

If you terminate your employment with the Company or are laid off, you will be paid for all unused floating holiday hours at your base rate of pay at the time of your termination.

Requests for use of Floating Holidays are limited to days that the employee is scheduled to work.

Unused floating holiday hours will convert to vacation in February of the following calendar year.

See "Excess Vacation Payout" and "How to Schedule or Defer Your Vacation."

Alternate Work Schedules

Please refer to your union agreement for details on floating holiday pay for employees on alternate work schedules.

Part-Time Employees

If you are a part-time employee, you may use floating holiday hours on days that you are regularly scheduled to work. The Company will pay part-time employees 8 hours whenever they use a floating holiday. This is regardless of the number of hours the part-time employee is scheduled to work on the day the floating holiday is taken. Example: Employee works four hours a day, Floating Holiday will equal 8 hours of floating holiday pay.

Voluntary Disability and Paid Family Leave Benefit Plan ("Voluntary Plan")

Pacific Gas and Electric Company offers the Voluntary Disability and Paid Family Leave Benefit Plan ("Voluntary Plan") to all eligible California union-represented, Management, Administrative, Technical and Security Utility employees.

California law requires that California employees participate in either the Voluntary Plan or the State Disability Insurance (SDI) and Paid Family Leave (CA PFL) Plan (collectively, "State Plan"). A Voluntary Plan must provide all the benefits of the State Plan, at least one benefit that is better, and it cannot cost employees more.

As a California Utility employee, you will be automatically enrolled in PG&E's Voluntary Plan, unless you opt out of coverage. If you opt out of the Voluntary Plan, you must participate in, and contribute to, the State Plan. Employees who elect to be covered under the State Plan can learn more by calling 1-800-480-3287 or visiting edd.ca.gov.

Voluntary Plan Paid Family Leave ("VPFL") benefits are described in this section. Voluntary Plan Disability Insurance ("VPDI") benefits are described in the *Sick and Disability section*. In the *Sick and Disability* section, you can also find more information about Voluntary Plan enrollment. For additional details and definitions, visit the Voluntary Disability and Paid Family Leave Benefit Plan Page on mypgebenefits.com for the Summary Statement of Coverage or the Voluntary Plan Document. In the event of any conflict between this Handbook and the formal Voluntary Plan document, the formal document controls.

Being approved for benefits under the Voluntary Plan does not provide job protection or return to work rights. The Voluntary Plan provides wage replacement only—it is not a type of leave of absence. For information about different types and eligibility for a leave of absence, see *Time Off and Leaves*.

The Voluntary Plan is not subject to ERISA.

Benefits and Payments

Benefit Amount

If your Voluntary Plan claim is approved, benefit payments will be made through your normal pay cycle, subject to limitations, at the applicable rate described below.

If you are a Benefit Class 1 employee (all regular, casual, probationary and regular-intermittent California employees), your weekly benefit amount is 60% of your weekly basic wage rate (subject to limitations and exclusions), with no weekly maximum imposed.

If you are a Benefit Class 2 employee (hiring hall, outage, temporary additional, probationary intermittent, and summer hire employees), your weekly benefit amount is 55% of your weekly basic wage rate (subject to limitations and exclusions), with no weekly maximum imposed.

As a requirement of the Voluntary Plan, your benefits will be no less than the weekly amount that would otherwise be paid by the State Plan.

Notwithstanding the above, the weekly benefit amount will be limited to the State Plan maximum weekly benefit amount for any day(s) you are eligible to receive benefits under a workers' compensation or employer liability law of California or any other state for either (i) temporary disability benefits, or (ii) permanent disability benefits for the same injury or illness.

In no event will the weekly benefit paid, in itself and/or in combination with any other wages, exceed 100% of your weekly basic wage rate.

For monthly-paid employees, your benefit will be calculated in weekly increments using your weekly basic wage rate and paid to you on your normal monthly pay cycle. This may represent a different amount than you are accustomed to on a monthly basis because PG&E's regular pay cycle pays you the same amount every month regardless of the number of workdays you work in any given month. Voluntary Plan benefits are weekly benefits representing your weekly basic wage rate.

For each day of any full-time continuous period of disability for which benefits are payable and which is less than a full week, the amount of benefit payable will be 1/7th of the amount of the weekly benefit, subject to wage loss calculations.

If you return to work and work part-time or intermittently and still suffer a wage loss during an eligible disability benefit period, benefits may continue to be paid on a wage loss basis. Wage loss is calculated by subtracting your current weekly wages while working part-time from your weekly basic wage rate. The difference between the two figures is your wage loss. If the wage loss is greater than your weekly VPDI benefit amount, you will receive benefits at your full VPDI rate. If the wage loss is less than your weekly VPDI amount, you will receive the amount of the wage loss only.

Weekly Basic Wage Rate

Basic Wage Rate means for the purpose of benefit determination, your regular pay excluding overtime, premium pay, bonuses, commissions, upgrades or other pay in effect, immediately prior to the commencement of a period of disability.

For the purposes of a benefit determination:

- A full-time employee's weekly basic wage rate is their monthly salary/wage, multiplied by 12 and divided by 52.
- A part-time employee's weekly basic wage rate is their part-time monthly wage, multiplied by 12 and divided by 52.
- An intermittent employee's weekly basic wage rate is a prorated amount based on the ratio of actual straight-time hours worked in the previous six-month period to the full-time hourly equivalent (1,040 hours per six-month period) rounded to the nearest month, multiplied by 12 and divided by 52.

Redirection of Benefits

You can redirect a portion of your Voluntary Plan benefits to cover certain other employee-paid benefits. If you'd like to redirect your Voluntary Plan benefits, submit your request through:

- PG&E@Work For Me > About Me > My Pay or My Benefits > Benefits Redirect. While on leave, your access to the portal will remain enabled, even with your other PG&E network access disabled.

OR

- If you do not have computer access or are otherwise unable to log in to the portal, email **Benefits@pge.com** to request a Voluntary Plan Benefits Deduction Redirect Form.

Visit Voluntary Disability and Paid Family Leave Benefit Plan on mypgebenefits.com under Time Off and Accommodations for more information and enrollment details.

Overpayments

If the calculation of benefits results in an overpayment for any reason, you are required to repay the overpayment to the Voluntary Plan to the extent permitted under applicable laws and regulations. The Company and the Leave and Disability Administrator will make reasonable arrangements with you for the repayment, including but not limited to, reduction of future Voluntary Plan benefits or the reduction of future pay, as allowed under applicable laws and regulations.

Simultaneous Coverage and Child Support Interception Deductions

For information on Simultaneous Coverage and Child Support Interception Deductions, refer to the Voluntary Plan Document on PG&E@Work intranet by searching Improved Short-Term Disability & Paid Family Leave Benefits. If you would like to request a paper copy of the Voluntary Plan document, please send an **email** to **PGELeaveteam@pge.com**.

Voluntary Paid Family Leave (VPFL)

Voluntary Paid Family Leave (VPFL) benefits are payable only if you comply with all requirements for payments of benefits as set forth in, and subject to the limitations provided within, the Voluntary Plan document. This includes your VPFL claim being supported by the applicable and complete documentation as defined and described in the Voluntary Plan.

Family Care leave/PFL benefit period means the period of unemployment beginning with the first day an employee establishes a valid VPFL claim to care for a seriously ill family member, to bond with a minor child, or to participate in a qualifying exigency related to the covered active duty or call to covered active duty of the employee's spouse, domestic partner, child, or parent in the Armed Forces of the United States. Periods of VPFL for the same care, bonding, or military recipient within a 12-month period will be considered one disability benefit period. Periods of VPDI for pregnancy and periods of VPFL for bonding associated with the birth of that child will be considered one disability benefit period.

The payment of all benefits is subject to the limitations and provisions stated in the Voluntary Plan Document.

In no event will you be eligible for more than a combined total of eight weeks of VPFL and CA PFL benefits during a 12-month period.

Eligibility

If you are covered employee, you may be eligible to receive VPFL benefits if you need to take time off work to care for a seriously ill family member (child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner), to bond with a new minor child (either by birth adoption, or foster care placement), or to participate in a qualifying event resulting from a family member's (spouse, registered domestic partner, parent, or child) military deployment to a foreign country (Qualifying Exigency).

VPFL must be taken concurrent with leave taken under the Family and Medical Leave Act (FMLA) and/or the California Family Rights Act (CFRA, if you are entitled to leave under the FMLA and/or the CFRA.

The following requirements must be met if the VPFL claim is to **care for a seriously ill family member**:

- You must file a claim with supporting documentation that provides satisfactory evidence that the care recipient requests your care and the care recipient's physician deems your care necessary.
- You must provide medical certification, in accordance with the requirements of the Voluntary Plan document, that shows that the care recipient has a serious health condition and requires care. This certification needs to be completed by the care recipient's physician or practitioner. The information provided must be within the physician's or practitioner's knowledge, must be based on a physical examination and documented medical history of the family member, and must contain all of the information required by the Voluntary Plan document.

- If a family member in good faith adheres to the teachings of a bona fide church, sect, denomination, or organization, and depends entirely upon prayer or spiritual means for healing, the family member's serious health condition may be supported by a certificate from a duly authorized and accredited practitioner of such church, sect, denomination, or organization. Such certificate must contain a certification of the care recipient's serious health condition that warrants the care of the employee and the estimated duration of the serious health condition.
- Benefits must be used within 12 months of the first day of family leave.

The following requirements must be met if the VPFL claim is to **bond with a new minor child**:

- You must file a claim with supporting documentation as required by the Voluntary Plan document that provides satisfactory evidence of the child's birth, adoption, or foster care placement and verifies the relationship of the employee to the child (not required for VPFL bonding claims transitioning from a pregnancy-related VPDI claim). The claim must contain all of the information required by the Voluntary Plan document.
- Benefits must be used within the first year after the birth, adoption, or foster care placement of the child.

The following requirements must be met if the VPFL claim is to **participate in a Qualifying Exigency**:

- You must file a claim with the required supporting military documentation and satisfactory documentation of the qualifying event. The claim must contain all of the information required by the Voluntary Plan document.

An employee is not eligible for VPFL benefits if:

- You are not suffering a loss of wages.
- You are claiming or receiving disability insurance, Unemployment Insurance, or workers' compensation.
- You are not working for PG&E at the time you begin PFL.
- The need for care is not supported by the certificate of a treating physician/practitioner, when leave is taken for the care of a family member
- You are not in the physical presence of your child, when leave is taken for bonding.
- Another family member is ready, willing, and able and available for the same period of time in a day that you are providing the required care for your family member with a serious health condition.
- You are in jail, prison, recovery home, or any other place because you were convicted of a crime.

VPFL benefits are not payable under the following conditions:

- For any days that you are eligible for unemployment insurance benefits from any state (including California).
- For any days that you are receiving wages or regular wages from any employer, except that you may receive wages plus VPFL benefits to the extent the combination does not exceed your regular weekly wage, excluding overtime pay, immediately prior to the commencement of the leave. "Wages" includes sick leave, or any non-specific leave provided by the Company if it is used for purposes of family leave. Vacation pay is not considered wages for determining eligibility for VPFL benefits. Note that you can no longer be required to take up to two weeks of earned but unused vacation leave prior to the initial receipt of VPFL benefits.
- If you are incarcerated, including, but not limited to, in a jail, medical facility, public or private hospital, because of a criminal conviction of a federal, state or municipal law or ordinance;
- For any days benefits are payable under a workers' compensation or employer liability law of any state (including California) for either (i) temporary disability benefits, or (ii) permanent disability benefits for the same injury or illness. However, VPFL benefits are payable for the difference between the VPFL weekly benefit amount and the temporary disability or permanent disability weekly benefit amount, provided that benefits will be limited to the State Plan Rate (weekly amount and maximum duration).
- For any period you are receiving benefits under a disability insurance act of any state (including California) or any company plan established in lieu of a state plan (such as VPDI).
- For any period another family member is ready, willing, able, and available to provide the required care.

Waiting Period

There is no waiting period for VPFL benefits.

Maximum VPFL Benefits Amount

The maximum amount payable during any period of PFL will be eight times the weekly benefit amount in a 12-month period or the amount that you would receive under the State Plan, if greater. VPFL bonding claimants transitioning from a pregnancy-related VPDI claim are entitled to eight weeks of VPFL benefits, regardless of the amount or duration paid on the VPDI claim.

Termination of VPFL Benefits

Your VPFL benefits will end when:

- Benefits have been paid through the date estimated by your family member's physician/practitioner that care is no longer required.
- Your family member recovers from their serious health condition or dies.
- Benefits have been paid through the end date of the qualifying military event (military exigency)
- You do not provide any required medical certification that your family member needs continued care.
- You have received eight weeks of VPFL benefits in a 12-month period.

Independent Medical Examinations (IMEs)

The Voluntary Plan may require additional medical information to verify medical eligibility for benefits, including requiring an Independent Medical Examination (IME). The Plan is responsible for the cost of the exam and any related tests. PG&E or the Leave and Disability Administration will have the right to require your family member, for which you are providing care and receiving VPFL benefits, to submit to an IME to determine the following:

- Whether a serious health condition exists.
- Whether your participation to provide care is warranted.
- The period that your participation to provide care is warranted.

If your family member fails to submit to an IME and follow the IME examination process, your claim may be subject to disqualification.

Claims Process for VPFL

You must provide advance notice of planned VPFL leave by contacting Sedgwick Claims Management Services, Inc. ("Sedgwick"), the Leave and Disability Administrator appointed by the Company to administer the claims filed under this Plan, at **1-855-732-8217** or online at **claimlookup.com/pge** and submitting the information requested. For unforeseeable events, you need to provide notification as soon as the need for leave is known.

To claim VPDI benefits under this Plan, you must file a claim with the Leave and Disability Administrator in a manner or fashion approved by the Leave and Disability Administrator. Claims may be submitted in writing, via telephone or electronically. Claim forms can be obtained by calling the Leave and Disability Administrator at 1-855-732-8217 or by accessing the website at **claimlookup.com/pge**. Completed forms must be sent to the Leave and Disability Administrator at PG&E Service Center, P.O. Box 14495, Lexington, KY 40512-4648, faxed to 1-866-856-4862 or uploaded to the website. Except for good cause, a complete claim must be filed no later than forty-one (41) days from the first (1st) day of VPFL. Along with that claim, you must file a medical certificate and/or appropriate supporting documentation, as required per Plan terms. You must also sign and file a claim form, including a medical release authorization, in order for the claim to be accepted and considered complete.

PG&E or its authorized administrator will have the right to:

1. require supplemental forms from the treating provider or those authorized to certify your disability as often as deemed necessary;

2. have you examined by a physician/practitioner while you are claiming benefits, as often as may be reasonably required during the period payment may be due under the Voluntary Plan; and
3. request additional medical certification as often as may be reasonably required during the period payment may be due under the Voluntary Plan.

Appeals Process for VPFL

If you are denied VPFL benefits, you may appeal the denial. You may appeal within 30 days after service of the denial. An employee may also appeal if the employee does not receive notice denying benefits within 30 days after the claim was sent to the Voluntary Plan. In such cases, the employee must file the appeal after 30 days and within 60 days from the date the claim was sent to the Voluntary Plan. In both cases of denial and lack of notice of denial, the employee must send the appeal to the EDD for processing. VPFL appeals must be sent to:

Paid Family Leave
PO Box 997017
Sacramento, CA 95899-7017

Separately, and additionally, you may appeal the denial by sending written notice to the Company's Leave and Disability Administrator and following its administrative procedures. These internal procedures are unrelated to the appeals process established pursuant to state law. Appealing a denied claim through the Leave and Disability Administrator's internal procedures may (but need not) be pursued simultaneously; however, this will neither suspend nor extend in any way the maximum time allowed for appealing benefits to the EDD.

Payment of Benefits Pending Appeal

As provided in the California Code of Regulations, you may elect to continue to receive VPFL benefits pending the outcome of a timely appeal to an administrative law judge when the Voluntary Plan had determined you initially eligible and subsequently found you to be ineligible.

PG&E Paid Family Leave (PFL)

The PG&E Paid Family Leave (PFL) policy applies to all Pacific Gas and Electric Company employees. PG&E's PFL policy offers a PFL Wage Continuation (supplemental) benefit to eligible employees.

The PG&E Wage Continuation payments supplement any benefits received under PG&E's Voluntary Paid Family Leave (VPFL) Plan, or a similar state disability program. PG&E pays the full cost of PFL supplemental benefits. You already pay for the cost of coverage for VPFL through payroll deductions.

For absences for which you are also eligible and qualify under the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), company leave policy or any other similar or local leave law, PFL runs concurrent with and does not extend the maximum period available. See "FMLA/CFRA Family Care Leave" for additional information on what qualifies under each leave entitlement.

If you are NOT a California employee

If you are an eligible employee and work outside of California, you are required to file a claim for State Disability and Paid Family Leave Insurance available to you in conjunction with your paid family leave in order to be eligible for PFL Wage Continuation. State Insurance programs do not typically provide job protection or return rights.

Below is a summary of the PG&E PFL policy. For additional details and definitions, please refer to the "Wage Continuation – Paid Family Leave Policy," which can be found on the Intranet in the Guidance Document Library.

Eligibility

Employees must be covered under the PG&E Voluntary Disability and Paid Family Leave Benefit Plan (Voluntary Plan) to be eligible for Wage Continuation benefits. California employees who opt-out of Voluntary Plan coverage will remain eligible for the CA PFL benefits.

If you are an eligible employee and work outside of California, PFL Wage Continuation supplements any state disability and paid family leave program for which you may be eligible.

If you are a hiring hall, temporary or intermittent employee who has not attained regular status, you are not eligible under the PFL policy. However, you may be eligible for CA PFL benefits or Voluntary Paid Family Leave benefits and a leave of absence under the FMLA, CFRA, or other similar state or local leave law.

In no event will you be eligible for more than a combined total of eight weeks of CA PFL and PG&E's PFL benefits during a 12-month period.

Claims Process

If you will be absent to care for a family member with a "Serious Health Condition" (as defined in the "Wage Continuation – Paid Family Leave Policy"), to bond with your new child within the first (1st) year of the child's birth, adoption or foster care placement, or due to participating in a Qualifying Exigency related to the covered active duty or call to covered active duty of the employee's spouse, domestic partner, child or parent in the Armed Forces, you must apply for PG&E PFL by contacting the Leave and Disability Administrator at 1-855-732-8217 or online at MySedgwick - accessible through PG&E@Work For Me >About Me > My Leaves or by visiting **claimlookup.com/pge**.

- You must provide 30 days' advance notice for a planned PFL leave period. For unforeseeable events, you need to provide notification as soon as the need for leave is known.
- Complete medical certification or documentation to support your bonding leave is required to be submitted to the leave and disability administrator, within the timeframe specified.
  - For family care events: A complete medical certificate from a treating Physician or Practitioner, acting within the scope of his/her practice, is required to be provided to the leave and disability administrator that establishes the sickness, injury, or pregnancy that warrants your care. The information provided must be within the Physician's or Practitioner's knowledge and will be based on a physical examination and documented medical history of your family member.
- If you are a California employee and you opt out of the Voluntary Plan, you are not eligible for the wage continuation benefits under the PFL policy.
  - You will continue to follow the leave of absence process and apply for the company child care/bonding leave and leaves provided under the FMLA, CFRA, PDL or local leaves, if eligible.
  - You will need to apply for CA PFL through the Employment Development Department (EDD). Payments for CA PFL benefits will be made directly by the EDD via a debit card.
- You must apply for VPFL benefits or other similar state benefits during the same leave period in which you are applying for PG&E PFL leave/benefits to be eligible for PFL Wage Continuation.
- Please note that, after PFL leave/benefits end, you may be eligible to extend your family care, bonding, or Qualifying Exigency leave under the FMLA, CFRA or Company Child Care/Bonding Leave.

If you are eligible for FMLA or CFRA, you will not need to file a separate leave of absence with the Leave and Disability Administrator. Your eligibility for FMLA and CFRA will be reviewed based on your PFL claim submittal and applicable documentation received. If you are qualified, you will be notified of your FMLA and CFRA running concurrently with your PG&E PFL.

Benefits and Payments

PFL Wage Continuation provides supplemental income replacement – up to 100% (before-tax) of your weekly basic wage rate prior to your first date of leave – to eligible employees who take approved time away from work to care for a seriously ill family member , bond with a new child, or to participate in a Qualifying Exigency. You may be eligible for up to eight weeks of PFL Wage Continuation Benefits.

PFL Wage Continuation Benefit payments will be made according to your normal pay cycle and the method of payment you've elected through PG&E's payroll department (i.e., direct deposit or live check). PFL Wage Continuation and VPFL benefit payments are processed separately and will not be reflected on the same paycheck.

- For monthly-paid employees: your PFL benefit will be calculated in weekly increments using your weekly basic wage rate. This may represent a different amount than you are accustomed to on a monthly basis because PG&E's regular pay cycle pays you the same amount every month regardless of the number of work days you

work in any given month. PFL benefits are weekly benefits representing your weekly basic wage rate and may not replace 100% of your *monthly* base pay. In addition, if your claim decision is made on the 25th of the month, your benefits will be paid according to your normal pay cycle the following the month.

- PFL Wage Continuation supplements VPFL benefits, or other similar state benefit, up to an equivalent of 100% of your weekly basic wage rate on the day prior to your first day of family or bonding leave.
  - There is no waiting period for VPFL or PFL wage continuation benefits.
  - There is no cap to the 100% PFL Wage Continuation Benefits.
  - VPFL benefits are federally taxable and PFL Wage Continuation benefits are fully taxable.
- For each day of an eligible full-time continuous PFL period due to caring for a family member with a serious health condition, bonding with a new child, or to participate in a Qualifying Exigency which is less than a full week, the amount of daily PFL Wage Continuation Benefit payable will be one-seventh of the amount of the weekly benefit.
- You may be eligible to receive PFL Wage Continuation Benefits on an intermittent basis for absences in which you are suffering a wage loss during an eligible PFL benefit period. (Amount is reduced by VPFL benefits and together with VPFL will not exceed 100% of pre-leave weekly basic wage rate.)
  - If the combined total of your wages and VPFL benefits equals or exceeds 100% of your pre-leave basic wage rate before taxes or any deductions, no benefits will be payable under the PFL Wage Continuation policy and this will not extend your eight weeks of PFL benefit duration.
- If you're taking leave for bonding purposes, the minimum PFL benefit period in which PFL Wage Continuation can be received is two weeks. However, on two occasions a leave and PFL benefit period of less than two weeks can be taken.

Basic Wage Rate: For purposes of determining PFL Wage Continuation Benefits, the "Basic Wage Rate" is defined as an employee's regular pay—excluding overtime, premium pay, bonuses, commissions, upgrades or other types of pay in effect—immediately prior to the commencement of a period of PFL. The Basic Wage Rate for employee will be calculated by multiplying the employee's monthly salary/wage rate by 12 and dividing by 52 to determine the weekly rate.

Maximum PFL Benefit/Leave Period

You may be eligible for up to eight weeks of PFL benefits/leave for qualifying events within a rolling 12-month period, subject to the limitations as described within this section or the Wage Continuation–Paid Family Leave policy document. This is a combined total of eight weeks of PFL Wage Continuation benefits for all reasons of PFL during a 12-month period.

You may be able to return to your former classification and work location for up to eight weeks under the PFL policy. If your position is eliminated, then you have no greater right to reinstatement or to other benefits and conditions of employment than if you had been continuously employed (working) during the PFL benefit period.

What Happens to Your Other Benefits

For health and welfare benefits information, contact PG&E's Benefits Service Center at **1-866-271-8144**.

Please refer to the Short-Term Incentive Plan (STIP) Standard (HR-1270S) for STIP eligibility during the eight weeks of PFL per calendar year.

You are eligible to continue to accrue vacation, Incidental Sick Time and Company Paid Holidays during a PFL benefit period. See "Illness While on Vacation" and "Vacation Program" and "Paid Holidays."

If you are participating in the Retirement Savings Plan (RSP) for Union-Represented Employees, your RSP contributions will continue at your current designation. You are eligible to receive RSP employer-matching contributions on PFL Wage Continuation benefit payments.

Denial of PFL Benefits and Leave

Employees are ineligible for and will be denied PG&E PFL benefits if any of the following apply:

- You are not suffering a loss of wages.

- You are claiming or receiving Unemployment Insurance (UI), disability benefits, or Workers' Compensation.
- You are no longer an active employee.
- You move into an ineligible Benefit Class (for example, you move into an IBEW-represented position). The effective date of the move is the date on which you become ineligible.
- The need for care is not supported by the Certificate of a treating physician/practitioner, you do not provide the required medical Certificate that the Care Recipient needs your continued care, the Care Recipient recovers from their Serious Health Condition or dies, the Care Recipient does not submit to an IME as required, does not provide a copy of the covered active duty orders or other documentation issued by the military that indicates your eligible military member is in the Armed Forces of the United States or does not provide supporting claim documents as set forth in the CUIC section 3307.
- The claim and/or the required paperwork is not submitted within the timeframe as specified by the leave and disability administrator.
- The maximum length of PFL has been reached.
- You are confined in jail, prison, recovery home, or any other place designated by the court because of a criminal conviction.
- You willfully make a false statement or knowingly conceal a material fact in order to obtain the payment of any benefits.
- You did not provide sufficient documentation in connection to a Qualifying Exigency related to the covered active duty or call to a covered active duty of an employee's spouse, domestic partner, child, or parent in the Armed Forces of the U.S.

PG&E PFL Wage Continuation Appeals

Employees who are denied PG&E PFL benefits will be provided one opportunity to appeal this decision directly through the Leave and Disability Administrator.

A period of no more than 30 calendar days will be provided to an employee to submit their appeal in writing directly to the Leave and Disability Administrator, along with any necessary and required information or documentation to support their claim for benefits. The appeal decision rendered by the leave and disability administrator will be final. PG&E PFL benefits are not payable during the appeal period, even if you are receiving VPFL benefits while an appeal is pending with the Employment Development Department (EDD).

For additional information on PFL Appeals, refer to the Wage Continuation – Paid Family Leave Policy on the Intranet in the Guidance Document Library or the Time Off and Accommodations section of mypgebenefits.com.

Limitations and Exclusions

- Employees are not eligible to receive more than eight weeks of PFL Wage Continuation benefits during a 12-month period.
- Employees who are being paid STD Wage Continuation are not eligible for PFL Wage Continuation payments.
- Except as described under the part-time and intermittent schedule, employees who receive pay from PG&E in any form will not be eligible for payments under the PFL policy on the same day. This includes, but is not limited to, receipt of sick pay, vacation pay, PTO, floating holidays, Company holidays, pay supplements or time off with pay.
- Employees may not delay the receipt of PFL Wage Continuation benefits for which he/she is eligible in order to extend the leave beyond the maximum FMLA, CFRA or Company leave time limits.

  For example: If you are eligible to receive benefits under the PFL Wage Continuation policy, you cannot choose to delay receipt of these benefits by using vacation, other pay or being unpaid during an approved leave period.
- PFL does not create a right for employees to take leave that exceeds the leave time allowed under or is in addition to the leave time permitted by, the FMLA, CFRA or Company leave.

- PFL for baby bonding cannot be taken prior to the birth or placement of the child or children.
- PFL for family care cannot be taken for the same period of time in a day for which another family member is ready, willing, able, and available to provide the required care.
- During a 12-month period, an employee is eligible to receive a maximum of eight weeks of PFL benefits for any combination of VPFL or CA PFL and PFL Wage Continuation Benefits.

  For example: An employee would not be eligible to receive eight weeks of VPFL or eight weeks of California Paid Family Leave Insurance benefits and then eight weeks of PFL Wage Continuation benefits.

San Francisco Paid Parental Leave Ordinance

The San Francisco Paid Parental Leave Ordinance (PPLO) offers a partial wage replacement (Supplemental Compensation) to eligible employees who are taking up to eight weeks of leave to bond with a new child and receiving compensations benefits under the California Paid Family Leave (CA PFL) program or PG&E's Voluntary Disability and Paid Family Leave Benefit Plan (Voluntary Plan). The CA PFL program provides a maximum weekly benefit for up to eight weeks of leave to bond with a new child. This Supplemental Compensation (up to eight weeks) is available only to employees who are eligible for and receiving CA PFL benefits, or PG&E's Voluntary Paid Family Leave (VPFL) benefits during a leave to bond with a new child. Depending upon their base wage rate, employees eligible for PG&E's VPFL may be entitled to VPFL benefits that are equal to or in excess of the benefits they would be entitled to under PPLO, in which case they will not receive additional PPLO benefits.

You will not receive additional PPLO pay if you already at or above 100% wage replacement. Therefore, if you are receiving PG&E PFL Wage Continuation benefits, which provides for up to eight weeks of benefits up to 100% of your weekly basic wage rate, you will not be eligible under for benefits under the PPLO .

Eligibility

The PPLO applies to any employee who is not eligible for coverage under PG&E's Paid Family Leave policy, which provides 100% wage replacement during qualifying leave periods and:

1. who began employment with PG&E at least 180 days prior to the start of the leave period;
2. who performs at least eight hours of work per week for PG&E in San Francisco;
3. for whom at least 40% of total weekly hours worked for PG&E are in San Francisco; and
4. who is eligible to receive paid family leave compensation under the CA PFL law for the purpose of bonding with a new child.

Claims Process

If you will be absent to bond with your new child within the first year of the child's birth, adoption or foster care placement and are requesting Supplemental Compensation through the PPLO program, you must apply for a leave of absence and PPLO benefits by contacting the **Leave and Disability Administrator at 1-855-732-8217** or online at **claimlookup.com/pge**.

- A complete San Francisco Paid Parental Leave Form is required to be submitted to the Leave and Disability Administrator, within the timeframe specified.
- You must apply for and be receiving California's PFL benefits during the same leave period in which you are applying for PPLO benefits in order to be eligible for PPLO Supplemental Compensation.
- In order to receive PPLO Supplemental Compensation, you must follow the instructions on the San Francisco Paid Parental Leave Form to ensure the Leave and Disability Administrator receives details of your CA PFL benefits.
- Payments for PPLO Supplemental Compensation will be made by PG&E according to the method of payment you've elected through PG&E's Payroll Department (i.e., direct deposit or printed check).

The PPLO does not create a right for you take a leave of absence. Your receipt of PPLO Supplemental Compensation runs concurrently with your leave to bond with your child under FMLA, CFRA and/or the Company Child Care/Bonding Leave, if you are eligible.

Maximum PPLO Supplemental Compensation Benefit

An employee's PPLO Supplemental Compensation will be in an amount such that the employee's CA PFL wage replacement, or PG&E VPFL wage replacement plus the PPLO Supplemental Compensation, equals 100% of the employee's gross weekly wage, subject to a cap, for up to eight weeks. If the PPLO Cap increases, then the PPLO Supplemental Compensation amount will increase as well. If an employee's PG&E VPFL benefit is already equal to or exceeds the PPLO Cap, the employee will not receive additional PPLO benefits.

Normal gross weekly wages: For purposes of determining PPLO Supplemental Compensation benefits, "normal gross weekly wages" are defined as an employee's regular pay, including overtime and shift premiums immediately prior to the commencement of a period where PPLO Supplemental Compensation benefits are due. Depending on the employee's payroll frequency, the timeframe for determining benefits will be the:

1. three monthly pay periods,
2. six bi-weekly or semi-monthly pay periods, or
3. 12 weekly pay periods

preceding the start of the first day of an employee's PPLO period (or preceding the first day of any increment of intermittent leave).

Additional information can be found on the Parental Leave pages on mypgebenefits.com (select Time Off and Accommodations > Leave of Absence.

Leaves of Absence

The Leave of Absence policy enables you to take time off for medical reasons (for you or an eligible family member), to care for and bond with a new child, for military duty, military exigency, or for other personal situations that are urgent and substantial. You may also be eligible under PG&E's STD policy (ESC-represented employees) or PFL policy to take a leave due to your own medical condition or the medical condition of a family member, for a qualifying exigency of a family member, or to bond with a new child. See *Leave and Disability* for more information on the STD policy that is available to ESC-represented employees. For more information on the PFL policy for ESC-represented employees, see "Personal Leaves of Absence."

Some of the leaves are legally-mandated by federal and/or state laws, such as the Family and Medical Leave Act (FMLA), the California Family Rights Act (CFRA), the Pregnancy Disability Leave Act (PDL), California Organ and Bone Marrow Donor Leave, the Fair Employment and Housing Act (FEHA), and the Uniformed Services Employment and Re-Employment Rights Act (USERRA). These leaves carry certain restrictions, employee eligibility criteria, limitations and obligations. Because most of our employees reside or work in the State of California, this Leaves of Absence section refers to California laws, when applicable. If a different state law applies, given an employee's state of residence or work location, the Company will comply with that state's requirements. See "Determination for Eligibility and Entitlements under FMLA/CFRA Leave."

Please note that while receiving job protection under FMLA/CFRA/PDL, the PG&E PFL policy, the PG&E STD policy or a Company leave, you have no greater right to reinstatement or to other benefits and conditions of employment than if you had been continuously employed during the leave period. Job protection offered by FMLA/CFRA/PDL, PG&E's STD or PFL policies, and the Company leaves entitle you to the same or a comparable position upon your return to work if such a position still exists. If your position is eliminated during your absence, you will be treated as if you were at work and may be afforded the Company's Workforce Management benefits.

Generally, federal- and state-mandated leave laws do not provide for paid time during a leave of absence. However, the Company may require the use of Capped Sick Time (ESC-represented employees) or sick leave (IBEW- and SEIU-represented employees) during certain situations. In addition, you may be eligible for wage replacement benefits under PG&E's Voluntary Disability and Paid Family Leave Benefit Plan (Voluntary Plan), the State's Disability Insurance and Paid Family Leave Plan (State Plan) and wage supplements under PG&E's STD (ESC-represented employees only) or PG&E's PFL policies. If you are not eligible to receive PG&E's STD or PFL benefits or benefits under the Voluntary Plan, you may elect to use vacation, or floating holidays, if applicable. More information on PG&E's STD policy and Voluntary Plan Disability benefits can be found in the *Sick and Disability and* section.

Foreseeable leaves must be requested through your supervisor and the Company's Leave and Disability Administrator 30 days in advance of the date your leave commences. Unforeseeable leaves must be requested as soon as your need for leave is known (as soon as practicable). If sufficient notice is not provided, your leave commencement date may be delayed, or your leave may be denied.

The different types of leaves which may be authorized are described in this section.

The following information is a summary only. You can access more information, including up-to-date details about the leave process/requirements, eligibility and pay during a leave, on mypgebenefits.com (select Time Off and Accommodations > **Leave of Absence**) on mypgebenefits.com or by contacting the **Company's Leave and Disability Administrator at 1-855-732-8217**.

Determination for Eligibility and Entitlements under FMLA/CFRA Leave

Eligibility for, and entitlement to, FMLA/CFRA Leave is complex. The reason for leave is how you determine whether or not the FMLA/CFRA Leave is a Medical Leave of Absence or a Personal Leave of Absence. The following information is provided to help you to better understand the requirements. See "Entitlement" and "Personal Leaves of Absence."

Eligibility

You are eligible for FMLA/CFRA Leave entitlements if you meet all of the following criteria:

- You have worked for the Company for at least 12 months (cumulative) as a full or part time employee. Employees who have met the 1,250-hour requirement but not the 12-month requirement when FMLA/CFRA leave starts can nonetheless meet the 12-month requirement while on leave;
- You have worked at least 1,250 hours in the 12 months that immediately precedes the date your leave commences. Only actual hours actually worked are used in this calculation, within the meaning of the California Labor Code and Industrial Welfare Commission Wage Orders, including straight and overtime hours (absences whether paid or unpaid are not used in this calculation);
- You do not have to requalify, in terms of the numbers of hours worked, in order to (1) take additional leave for the same qualifying event during the employee's 12-month leave period or (2) if you have been approved for FMLA/CFRA and regain FMLA/CFRA entitlement after exhaustion; and
- You have not exhausted the 12 weeks of FMLA/CFRA entitlement in a rolling 12-month period, as described under "Entitlement," below.

A period of absence for military service counts as time worked toward your eligibility for leave under FMLA/CFRA.

Entitlement

The Company uses a rolling 12-month period measured backward from the date you use any FMLA/CFRA leave to determine your available 12-week entitlement.

Every rolling 12-month period, you may be eligible for up to a total of 12 weeks of FMLA/CFRA leave time for the following reasons:

- For the birth of a child, or to bond with a newborn, newly-adopted, or newly-placed foster child (leave must be taken within 12 months of the birth, adoption or foster placement);
- To care for a serious health condition of a spouse, parent, or child (a child is a minor or adult incapable of caring for themselves because of a mental or physical disability). The CFRA also permits taking leave to care for a serious health condition of a registered domestic partner, adult child who is capable of self-care, parent-in-law, grandparent, grandchild, sibling, or "designated person." (A "designated person" means any individual related by blood or whose association with the employee is the equivalent of a family relationship); and/or
- For your own "serious health condition," as defined by the laws.
    - Under California's the Pregnancy Disability Leave (PDL) Law [provisions of the Fair Employment and Housing Act (FEHA, employees **who are disabled due to pregnancy** are eligible for up to four months of pregnancy disability leave, if medically necessary as determined by a health care provider, regardless of

any other FMLA/CFRA leave they have already taken during the previous 12-month period. Employees may take up to four months of pregnancy disability leave followed by 12 work weeks of CFRA leave for bonding with the new baby. Employees may take up to four months of PDL followed by 12 work weeks of CFRA leave for bonding with the new baby.

- Because of any qualifying exigency arising out of the fact that an employee's spouse, domestic partner, son, daughter, or parent who is a member of the Armed Forces (including National Guard and Reserves) and who is on covered active duty or has been notified of an impending call or order to covered active duty.
- **FMLA Military Caregiver Leave** — under the FMLA only, an eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member/veteran shall be entitled to a total of 26 workweeks of leave during a single 12-month period to care for the service member/veteran. The leave described in this paragraph shall only be available during a single 12-month period. Please see "Personal Leaves of Absence" for more information on this leave.

  If the leave is common to both CFRA and FMLA, the 12-month period under each law runs concurrently. When you take time off for any of the FMLA/CFRA reasons listed above, the time off is "subtracted" from your 12 week entitlement during that 12-month period. Taking time off in the following situations will not result in time being "subtracted" from your 12-week CFRA entitlement: For a pregnancy-related condition, if covered under PDL; to care for an injured service member under FMLA Military Caregiver Leave; or for exigency leave due to a call to covered active duty. Time off under FMLA/CFRA may be taken on a continuous, intermittent or reduced schedule basis as appropriate (please see "Personal Leaves of Absence" for restrictions when taking time off intermittently for child bonding reasons).

  Qualifying for an FMLA/CFRA leave is dependent upon how much total FMLA/CFRA leave time you have already taken in the previous 12 rolling months for any of these combined reasons. You need to meet the eligibility requirements for each new leave requested.

- If you have not taken any FMLA/CFRA leave time in the previous 12 months for bonding with a newborn, newly-adopted or newly-placed foster child; the care of a spouse, registered domestic partner, parent or child (including the child of a registered domestic partner), or "designated person" with a serious health condition; for a qualifying exigency due to a spouse, domestic partner, son or daughter, or parent who is on covered active duty or has been notified of a call to covered active duty in the Armed Forces; or for your own serious health condition (other than pregnancy), you may apply for up to 12 weeks of FMLA/CFRA leave for any of the reasons listed.
- If you have taken less than 12 weeks of FMLA/CFRA leave in the previous 12 months for any of the reasons listed, you may apply for the balance of your 12-week FMLA/CFRA leave.
- If you have already taken your full 12 weeks of FMLA/CFRA leave in the previous 12 months, you are not entitled under FMLA/CFRA to take further FMLA/CFRA leave for the reasons listed. However, you may be eligible for a medical or personal leave under the Company-provided leaves (see "Entitlement" and "Personal Leaves of Absence"). Once you have regained available FMLA/CFRA entitlements, you may apply for additional FMLA/CFRA leave (you will need to meet the hours worked requirements in order to be eligible for another FMLA/CFRA leave).
- If you take a leave for medical or personal reasons which meet the requirements and definitions of FMLA/CFRA, your leave will be counted against your 12-week FMLA/CFRA entitlement.
- During the single 12-month period as described in the FMLA Military Caregiver Leave, you may be eligible to take a combined total of 26 workweeks of leave for this reason and any of the reasons listed.

Medical Leaves of Absence

You may request medical leave as provided for by the Family and Medical Leave Act (FMLA) and/or California Family Rights Act (CFRA) if you have a "serious health condition," as defined by the laws (including work-related injuries that meet this definition). In addition, if your requested medical leave is pregnancy-related, you may request a Pregnancy Disability Leave (PDL) as provided for under the Fair Employment and Housing Act (FEHA) or if donating an organ or bone marrow, your leave may be covered under the California Organ and Bone Marrow Donor Leave.

A Company Medical Leave of Absence may be granted to eligible regular-status employees who are unable to work for more than 10 consecutive workdays, due to illness or injury and are not receiving PG&E's STD Wage Continuation benefits.

ESC-represented employees who are eligible under PG&E STD Policy are not eligible for the Company Medical Leave of Absence. Eligibility under PG&E's STD policy covers both leave and wage supplements. Please refer to *Leave and Disability* for more information on PG&E's STD leave/benefits and Voluntary Plan benefits. If your absence also falls under the STD policy and you apply for these benefits, you will not need to file a separate leave of absence with the Leave and Disability Administrator for an FMLA/CFRA or PDL medical leave as well as the Voluntary Plan Benefits. Your eligibility for an FMLA, CFRA or PDL will be reviewed based on your STD claim submittal and applicable documentation received. If you are qualified, you will be notified of your FMLA, CFRA or PDL running concurrently with your STD leave.

You have the right to elect to continue your existing Company health care plan coverage during your medical leave of absence.

You can access more information on the **Leaves of Absence** page at mypgebenefits.com or by contacting the **Company's Leave and Disability Administrator at 1-855-732-8217.**

If you are on a medical leave of absence, including STD leave, or you are an employee with a disability, you can request a reasonable accommodation (which may include additional time off) in order to perform the essential functions of your job to return from leave or remain at work. For more information on eligibility and how to obtain a request form, please refer to the **Workplace Accommodations and Internal Job Search Program** page under the "Time Off and Accommodations" tab on mypgebenefits.com, **email** the Accommodation Team at **Accommodations-Req@pge.com**, or see *Leave and Disability*.

If you are a California employee

If you have opted out of the Voluntary Plan you may be eligible for State Disability Insurance (SDI) offered by the Employment Development Department of California (EDD) during your medical leave of absence. The Company does not coordinate paid sick pay with VPDI and SDI benefits. VPDI and SDI does not provide job protection or return rights. See the Sick and Disability section for more details and a comparison of VPDI and SDI benefits.

You may be eligible for Voluntary Plan Disability Insurance (VPDI) Benefits if you are covered under PG&E's Voluntary Disability and Paid Family Leave Benefit Plan (Voluntary Plan) during your medical leave of absence.

FMLA/CFRA Medical Leave

Pursuant to the FMLA and CFRA laws, if you are an eligible employee and have a qualifying event or condition and/or are unable to work for more than three consecutive calendar days and require continuing treatment due to your own "serious health condition" (as defined by the FMLA and CFRA), you may take up to 12 weeks of paid or unpaid FMLA/CFRA leave in a rolling 12month period. If the leave is taken due to pregnancy disability, you are entitled to up to four months of medical leave while disabled due to pregnancy, pursuant to FEHA. This four-month leave is separate from any child care/bonding leave which is available pursuant to the FMLA or CFRA laws and/or Company leave policies. FMLA/CFRA may be used on a continuous, intermittent, or reduced schedule basis, as medically necessary. Medical certification of a "serious health condition" is required. See "Determination for Eligibility and Entitlements under FMLA/CFRA Leave" for more information about eligibility and entitlement limitations.

Employees who are receiving disability benefits have the option not to use sick time if you are receiving disability or paid family leave benefits during a FMLA/CFRA medical leave.

For absences with a date of disability on or after January 1, 2017, ESC-represented employees should refer to Leave and Disability for more information on pay requirements and benefits available under the STD policy during FMLA/CFRA Medical Leave.

The use of paid time, including when you are receiving STD benefits, does not extend the maximum period of leave as provided for under FMLA/CFRA. You are not eligible to use paid time intermittently or on a reduced schedule when on a continuous leave of absence. FMLA/CFRA medical leave runs concurrently with a Company Medical Leave and STD (ESC-represented employees only), if you are eligible. FMLA/CFRA medical leave runs concurrently with approved Workers' Compensation absences, when applicable.

The Company may require a second and third opinion for certification of your own serious health condition, and medical re-certification may be required when applicable. A release to return to work form is required for absences two weeks or longer, or as the condition merits. When released to return to work, you may generally return to your former or an equivalent position and work location.

A Leave of Absence must be initiated for job protection through the Company's Leave and Disability Administrator, and a valid medical certification may be required for approval. Thirty days' advance notice is required when the leave is "foreseeable."

Pregnancy Disability Leave (PDL)

The PDL Act under the Fair Employment and Housing Act (FEHA) requires the Company to provide employees up to four months (equivalent to 88 workdays for full-time employees) of paid or unpaid, job-protected leave, if medically necessary, for a disability on account of pregnancy, prenatal care, childbirth, or related medical conditions. This leave is separate from any child care/bonding leave which is available pursuant to the FMLA or CFRA laws; however, PDL and FMLA may run concurrently during the pregnancy-related absence. FEHA also provides for an employee affected by pregnancy the ability to request a transfer to a less strenuous or hazardous position/duties if her health care provider certifies it is medically advisable to do so. There is no service requirement to be eligible for PDL (employee must work in California). PDL can be used on a continuous, intermittent or reduced schedule basis, as medically necessary. Medical certification of disability or medically advisable transfer is required.

For absences with a date of disability on or after January 1, 2017, ESC-represented employees should refer to *Leave and Disability* for more information on pay requirements and benefits available under the STD policy during a PDL Medical Leave.

The use of paid time, including receiving STD or Voluntary Plan benefits, does not extend the maximum period of leave as provided for under PDL. You are not eligible to use paid time intermittently or on a reduced schedule when on a continuous leave of absence. Unpaid continuous PDL of more than 10 consecutive workdays runs concurrently with the Company Medical Leave, if you are eligible.

PDL runs concurrently with FMLA and STD (if you are eligible) for pregnancy-related disability or consecutively with FMLA/CFRA and PFL (if you are eligible) for child-bonding purposes, if you are eligible and have not exhausted your FMLA/CFRA entitlement within the rolling 12-month period prior to your child bonding leave starting.

Medical re-certification may be required when applicable. A release to return to work form is required for absences two weeks or longer or as the condition merits. When released to return to work from PDL, you may return to your former position and work location.

A Leave of Absence must be initiated for job protection through the Company's Leave and Disability Administrator and a valid medical certification may be required for approval. Thirty days' advance notice is required when the leave is "foreseeable." If a transfer is needed, please refer to the **Workplace Accommodations and Internal Job Search Program** page under the "Time Off and Accommodations" tab on mypgebenefits.com, where you can obtain a request form, or **email** the Stay At Work/Return to Work Team at **Accommodations-Req@pge.com**.

Should you choose to breastfeed or chestfeed, you can find information on Lactation Rooms and your entitlement to breaks to express milk at mypgebenefits.com >Mental Health and Family Support > Lactation Rooms.

California Organ and Bone Marrow Donor Leave

If you have been employed by the Company at least 90 days immediately preceding the commencement to your leave, you are eligible for the Organ and Bone Marrow Donor Leave. Medical Certification that you are an organ or bone marrow donor and that there is a medical necessity for the donation of the organ or bone marrow is required. Leave may be taken in one or more periods. When released to return to work, you may generally return to your former or an equivalent position and work location.

Organ and Bone Marrow Donor Leave do not run concurrently with leave taken under the FMLA or CFRA. However, you may be able to extend your leave of absence beyond the time period covered under the organ (60 days) and bone marrow (five days) provisions by requesting an extension under the FMLA, CFRA, Company Medical Leave of Absence (MLOA) and/or STD Leave (ESC-represented employees).

The Leave of Absence must be initiated for job protection through the Company's Leave and Disability Administrator and a completed Medical Certification form must be submitted for approval. Thirty days' advance notice is required when the leave is "foreseeable."

Organ Donor Leave

You are eligible for up to 30 days of paid leave and an additional 30 days of unpaid leave in a rolling 12-month period in order to donate an organ. If you have available Incidental/Capped/Sick and/or Vacation pay, you are required to use up to two weeks of your available paid time first in the specified order, according to the provisions of each type of pay. Available Incidental/Capped/Sick pay must be used and exhausted prior to available vacation pay. If your organ donor leave extends beyond two weeks or you do not have two weeks of paid time available, the remaining portion of your 30-day leave will be paid by the Company.

The law provides for up to 30 days of **paid** organ donor leave and an additional 30 days of unpaid leave. If your absence is longer than 30 days, normal company pay policies will apply beginning the 31st day through the remainder of your absence.

For example, if you are an IBEW- or SEIU-represented employee extending your leave beyond 30 days and still have available sick pay after using your two weeks of sick time at the onset of the leave per Company policy, you will be required to use any additional sick pay time beginning day 31 and may extend your leave under the FMLA, CFRA and/or CMLOA.

If you are an ESC-represented employee and you are extending your leave beyond 30 days, you must apply for STD leave with the Leave and Disability Administrator and you may also be eligible under the FMLA and/or CFRA. If you have available Capped Sick Time, and you are not FMLA and/or CFRA eligible, this will be used and exhausted first. If you are FMLA and/or CFRA eligible, you have the option not to use your Capped Sick Time. Your absence must be supported by medical certification and meet the definition of disabled under the STD policy.

Bone Marrow Donor Leave

You are eligible for up to five days of paid leave in a rolling 12-month period in order to donate bone marrow. If you have available Incidental/Capped/Sick and/or Vacation pay, you are required to use up to five days of your available paid time first. Available Incidental/Capped/Sick pay must be used and exhausted prior to available vacation pay. If your available paid time is less than five days, the remaining portion of your five-day leave will be paid by the Company.

The law provides for up to five days of **paid** bone marrow donor leave. If your absence is longer than five days, you may take additional time by applying for FMLA/CFRA leave.

If you are an ESC-represented employee and you are extending your leave beyond five workdays (seven consecutive calendar days), you must apply for STD leave with the Leave and Disability Administrator and you may also be eligible under the FMLA and/or CFRA. If you have available Capped Sick Time, this will be used and exhausted first. Your absence must be supported by medical certification and meet the definition of disabled under the STD policy.

Company Medical Leave (CMLOA)

ESC-represented employees who are not eligible under the STD leave policy may be eligible for a Company Medical Leave of Absence, as defined in this section. If your date of disability is on or after January 1, 2017, please refer to *Leave and Disability* for more information, as this section may not be applicable to you. IBEW- and SEIU-represented employees may be eligible for a Company Medical Leave of Absence, as defined in this section.

If you are a regular-status employee , you may be eligible for an unpaid Company Medical Leave due to illness and/or injury.For a CMLOA,a physician's statement defining your current work limitations and capabilities, the specific job functions you are unable to perform, your planned treatment and the estimated length of disability is required on the medical certification (there needs to be sufficient medical information to support your requested medical leave). A CMLOA is an unpaid absence of more than 10 consecutive workdays and cannot be taken on an intermittent basis or on a reduced schedule. CMLOA may run concurrently with an unpaid, continuous FMLA/CFRA/PDL leave.

The leave ends when you are released to return to work, with or without reasonable accommodations, or qualify for Long-Term Disability benefits. A CMLOA may be granted for a period not in excess of six consecutive months.

An extension may be granted for up to an additional six months if the circumstances warrant. The maximum length of an unpaid medical leave, including extensions, is 12 consecutive months in combination with all other leaves, excluding a military leave, or until you qualify for Long-Term Disability benefits. You may be required to be examined by a panel physician during your leave and/or prior to your return to work. Medical re-certification may be required when applicable. A release to return to work form is required for absences two weeks or longer or as the condition merits. When released to return to work, you may generally return to your former or an equivalent position and work location. A request for CMLOA may not be granted based on your history of overall unavailability and service to the Company. For example, if the granting of leave(s) has not proven effective in increasing your ability to return to work and/or remain at work, additional leave may not be granted.

If you fail to return immediately on the expiration of your approved CMLOA, accept other employment while on a CMLOA (with certain exceptions), or make an application for unemployment benefits while on a CMLOA, you will no longer be considered on an approved CMLOA and your employment with the Company will end. This leave will not be granted to cover a period of incarceration or if the purpose for which it is requested may lead to your resignation.

The Leave of Absence must be initiated through the Company's Leave and Disability Administrator and a completed medical certification form must be submitted for approval. Thirty days' advance notice is required when the leave is "foreseeable."

Personal Leaves of Absence

The Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) require employers to grant eligible employees up to 12 weeks of paid or unpaid leave within a rolling 12-month period for specified family-related reasons (or up to 26 weeks for the FMLA Military Caregiver Leave in a single 12-month period). The Company may grant additional leaves of absence without pay to eligible regular-status employees for qualifying reasons and service to the Company.

You have the right to elect to continue your existing Company health care plan coverage during your personal leave of absence; however, the amount you pay may increase depending on the duration of your personal leave. Contact PG&E's Benefits Service Center at **1-866-271-8144** for additional information.

You can access more information on the **Leaves of Absence** page at mypgebenefits.com or by contacting the Company's **Leave and Disability Administrator at 1-855-732-8217**.

FMLA/CFRA Family Care Leave

The four types of FMLA/CFRA Family Care Leave are described in this section. See "Eligibility" and "Entitlement" for more information about eligibility and entitlement limitations.

ESC-represented employees with a new qualifying event on or after January 1, 2017 and IBEW- and SEIU-represented employees with a new qualifying event on or after January 1, 2018, may be eligible for PG&E Paid Family Leave (PFL), as defined in "PG&E Paid Family Leave (PFL)," during a period of FMLA/CFRA Family Care Leave. If your absence also falls under the PFL policy and you apply for these benefits, you will not need to file a separate leave of absence with the leave and disability administrator for FMLA/CFRA leave. You will follow the pay information as described in the PFL policy and your eligibility for FMLA or CFRA will be reviewed based on your PFL claim submittal and applicable documentation received. If you are qualified, you will be notified of your FMLA and CFRA running concurrently with your PFL leave.

If You Are a California employee

You may be eligible for up to eight weeks of Voluntary Paid Family Leave (VPFL) and PG&E PFL Wage Continuation Benefits if you are covered under PG&E's Voluntary Disability and Paid Family Leave Benefit Plan (Voluntary Plan) during your family care leave of absence.

If you have opted out of the Voluntary Plan, you may also be eligible for up to eight weeks of State Paid Family Leave (CA PFL) offered by the California Employment Development Department (EDD) during your family care leave of absence.

The Company does not coordinate paid time with VPFL or CA PFL benefits. VPFL and CA PFL do not provide job protection or return rights. See Leave and Disability for more details and a comparison of VPFL and CA PFL benefits.

You have the right to elect to continue your existing health care plan coverage during your family care leave of absence; however, the amount you pay may increase depending on the duration of your leave. Contact PG&E's Benefits Service Center at **1-866-271-8144** for additional information. If you're receiving Voluntary Plan Disability Insurance (VPDI) benefits, you may elect to continue to pay all or a portion of your monthly healthcare premiums using approved benefits you're receiving from PG&E's VPDI. This option will prevent you from having to pay the balance (or a portion of your balance) for your unpaid benefit premiums when you return to work. Visit mypgebenefits.com > Time Off and Accommodations > Voluntary Disability and Paid Family Leave Benefit Plan for more information and enrollment details.

You can access more information, including the leave process and requirements, from the Leaves of Absence page (on the Time Off and Accommodations tab) of mypgebenefits.com or by contacting the **Company's Leave and Disability Administrator at 1-855-732-8217**.

Leave for the Birth of a Child and/or to Bond with a Newborn, Newly-Adopted or Newly-Placed Foster Child

If you need time off for the birth and/or to bond with a newborn child, a newly-adopted child or a newly-placed foster child (including a newborn child, a newly-adopted child or a newly-placed foster child of a registered domestic partner with whom you will stand in loco parentis), you may request up to 12 weeks of paid or unpaid FMLA/CFRA leave, to be completed within one year of the child's birth, adoption or foster placement.

Voluntary Paid Family Leave (VPFL) or California Paid Family Leave (CA PFL) benefits and PG&E PFL benefits must be taken concurrent with FMLA and/or CFRA, if you are eligible. If you are not receiving VPFL or PG&E Paid Family Leave, you may request to use any available vacation/PTO, floating holidays or in-lieu-of-holiday, subject to your supervisor's approval.

The use of paid time, including receiving VPFL and PG&E PFL benefits, runs concurrently with and does not extend the maximum period of leave as provided for under FMLA/CFRA. You are not eligible to use paid time intermittently or on a reduced schedule when on a continuous leave of absence. FMLA/CFRA child-bonding leave runs concurrently with PG&E Paid Family Leave and unpaid continuous FMLA/CFRA child-bonding leave of more than 10 consecutive workdays runs concurrently with the Company Child Care/Bonding Leave, if you are eligible.

Minimum duration of CFRA leave is two weeks for the birth, adoption, or foster placement of a child. However, the Company shall grant a request for a CFRA leave of less than two weeks' duration on any two occasions. FMLA does not require the Company to provide intermittent or reduced leave schedule for child care leave; the Company applies the CFRA-criteria to FMLA in this case. A return to your former or equivalent position and location is generally guaranteed.

Under the FMLA, spouses who both work for the Company share their FMLA entitlements when both take leave for this reason. Under the CFRA, each parent is entitled to the full 12 weeks of leave for baby bonding.

A Leave of Absence must be initiated for job protection through the Company's Leave and Disability Administrator and appropriate documentation must be submitted for approval. Thirty days' advance notice is required when the leave is "foreseeable." If not foreseeable, notice must be given as soon as practicable.

Leave to Care for a Spouse, Registered Domestic Partner, Parent, Parent-in-law, Grandparent, Grandchild, Sibling, Child, or "designated person" with a Serious Health Condition (Registered Domestic Partner, Parent-in-law, Grandparent, Grandchild, and Sibling, and "designated person" are covered by CFRA only).

If you need time off to care for a spouse, registered domestic partner, parent, parent-in-law, grandparent, grandchild, sibling, child (including the child of a registered domestic partner), or "designated person" with a serious health condition, you may be eligible to take up to 12 weeks of paid or unpaid FMLA/CFRA leave in a rolling 12-month period. Medical certification of a "serious health condition" (as defined by the FMLA/CFRA) is required. Leave may be taken on a continuous, intermittent or reduced schedule basis. A return to your former position and work location is guaranteed unless the employee would not have been employed at the time of reinstatement (i.e., due to the position being eliminated, the employee no longer being qualified for the position, a companywide reduction in work force, etc.).

A child is defined as: biological, adopted, foster child, step-child, legal ward, or child of a person standing *in loco parentis*, who is:

- Under the FMLA:
  - Under 18 years of age; or
  - 18 years of age or older and incapable of self-care due to mental or physical disability within the meaning of Government Code section 12926, subdivisions (i) and (k) and/or the Americans with Disabilities Act (ADA).
- Under the CFRA: a child of any age.

A parent is defined as: biological, adoptive, step or foster mother or father, or other person who stood *in loco parentis* to the employee when the employee was a child.

A "designated person" is any individual related by blood or whose association with the employee is the equivalent of a family relationship and must be identified by the employee when they request leave.

If eligible, Voluntary Paid Family Leave (VPFL) or California Paid Family Leave (CA PFL) benefits and PG&E PFL benefits must be taken concurrent with FMLA and/or CFRA, if you are eligible. When on a CFRA leave to care for a family member, if you are not receiving VPFL, PG&E Paid Family Leave or CA PFL benefits, you may use your available Family Sick Leave (FSL) or request vacation/PTO, floating holidays, or in-lieu-of-holiday (paid time other than FSL pay is subject to your supervisor's approval). If your absence is not protected under the CFRA and you are not receiving VPFL or CA PFL benefits, FSL must be used in accordance with the Leave and Disability provisions prior to being unpaid.

The use of paid time, including receiving VPFL and PG&E PFL benefits, does not extend the maximum period of leave as provided for under FMLA/CFRA. You are not eligible to use paid time intermittently or on a reduced schedule when on a continuous leave of absence. FMLA/CFRA family leave runs concurrently with PG&E Paid Family Leave and unpaid continuous FMLA/CFRA of more than 10 consecutive workdays runs concurrently with a Company Personal Leave of Absence, if you are eligible.

A Leave of Absence must be initiated for job protection through the Company's Leave and Disability Administrator and a valid medical certification must be submitted for approval. Thirty days' advance notice is required when the leave is "foreseeable."

FMLA and CFRA Military Exigency Leave

If you need time off because of any qualifying exigency due to a spouse, child, domestic partner (CFRA only), or parent who is on covered active duty or has been notified of an impending call or order to covered active duty in the US Armed Forces (including the National Guard and Reserve), you may be eligible to take up to 12 weeks of

paid or unpaid FMLA and CFRA leave in a rolling 12-month period. Leave may be taken on a continuous, intermittent, or reduced schedule basis. A return to your former or equivalent position and work location is generally guaranteed.

Covered active duty means:

- For members of a Regular Component of the Armed Forces, covered active duty is duty during the deployment of the member with the Armed Forces to a foreign county.
- For members of a Reserve Component of the Armed Forces (including members of the National Guard and Reserve, covered active duty is duty during the deployment of the member with the Armed Forces to a foreign country under a call or order to active duty in a contingency operation (further explained under a provision of law referred to in section 101(a)(13)(B) of title 10, United States Code).

Deployment to a foreign country means deployment to areas outside of the United States, the District of Columbia, or any Territory or possession of the United States. It also includes deployment to international waters.

You may elect to use any available vacation, in-lieu-of-holiday, or floating holidays, subject to your supervisor's approval. The use of paid time does not extend the maximum period of leave as provided for under FMLA and/or CFRA. You are not eligible to use paid time intermittently or on a reduced schedule when on a continuous leave of absence. Unpaid continuous FMLA and/or Exigency leave of more than 10 consecutive workdays runs concurrently with the Company Personal Leave, if you are eligible. Your Exigency leave may also be covered under and run concurrently with the California leave for Spouses of Deployed Military Personnel.

A Leave of Absence must be initiated for job protection through the Company's Leave and Disability Administrator and be supported by appropriate documentation which may include a copy of the military member's active-duty orders. Reasonable and practicable advance notice is required when the leave is

FMLA Military Caregiver Leave

If you need time off as a spouse, son, daughter, parent, or next of kin to care for a covered service member for a serious injury or illness incurred in the line of duty on active duty, you may be eligible to take up to 26 workweeks of paid or unpaid leave during a single 12-month period. Leave may be taken on a continuous, intermittent or reduced schedule basis, as medically necessary. Medical certification is required. A return to your former or equivalent position and work location is generally guaranteed.

A covered service member is either:

- A **current** member of the Armed Forces (including a member of the National Guard and Reserve) who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is on the temporary disability retired list, for a serious injury or illness; or
- A **veteran** who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness and who:
  - was a member of the Armed Forces (including a member of the National Guard or Reserve)
  - was discharged or released under conditions other than dishonorable; and
  - was discharged within the five-year period preceding the date the eligible employee first takes FMLA military caregiver leave to care for the veteran (special rules apply to determine the five-year period)

CFRA will run concurrently with FMLA Military Caregiver Leave when leave is taken for an eligible family member as provided for under the CFRA. FMLA/CFRA leave runs concurrently with PG&E Paid Family Leave and unpaid continuous FMLA Military Caregiver leave of more than 10 consecutive workdays runs concurrently with a Company Personal Leave of Absence, if you are eligible.

Voluntary Paid Family Leave (VPFL) or California Paid Family Leave (CA PFL) benefits and PG&E PFL benefits must be taken concurrent with FMLA and/or CFRA, if you are eligible. If your absence is not protected under the CFRA and you are not receiving VPFL, PG&E PFL or CA PFL benefits, available Family Sick Leave (FSL/Sick Relative) must be used and exhausted prior to being unpaid or requesting vacation or floating holiday pay (paid time other than FSL pay is subject to your supervisor's approval) during a FMLA Military Caregiver leave. The use of paid time, including receiving VPFL and PG&E PFL benefits, does not extend the maximum period of leave as

provided for under FMLA or CFRA. You are not eligible to use paid time intermittently or on a reduced schedule when on a continuous leave of absence.

Spouses employed by the same employer are limited to a **combined** total of 26 workweeks in a "single 12-month period" if the leave is to care for a covered service member with a serious injury or illness.

A Leave of Absence must be initiated for job protection through the Company's Leave and Disability Administrator and a completed Health Care Provider Certification must be submitted for approval. Thirty days' advance notice is required when the leave is "foreseeable."

Company Personal Leaves

Company Child Care/Bonding Leave

Under the Company's policy, if you are a regular-status employee, you may request an unpaid Company Child Care/Bonding Leave of up to six months if you need time off to bond with a newborn child, a newly-adopted child, or a newly-placed foster child (including the newborn child, a newly-adopted child or a newly-placed foster child of a registered domestic partner). An additional six months of leave may be requested; however, the maximum length of this leave, including extensions, is 12 consecutive months in combination with all other leaves and PG&E Paid Family Leave, excluding a military leave. This leave must be taken and completed within three years following the birth, adoption or foster placement of your child. This leave is an unpaid absence of more than 10 consecutive workdays and cannot be taken on an intermittent or reduced schedule basis.

The Company Child Care/Bonding Leave is available once per qualifying event/child and runs concurrently with an unpaid, continuous FMLA/CFRA leave and PG&E Paid Family Leave, if you are eligible. Receipt of Voluntary Paid Family Leave (VPFL) or State PFL benefits also run concurrently with and do not extend the amount of time available under the Company Child Care/Bonding Leave.

If your leave is completed within six consecutive months, return to your former or equivalent position and work location is generally guaranteed. If you extend your Company Child Care Leave beyond six consecutive months, you may return to work provided a vacancy in your position and headquarters, or a lower position in your headquarters, exists. If a vacancy of this kind does not exist, then your employment with the Company will be terminated. This leave will not be granted to cover a period of incarceration or if the purpose for which it is requested may lead to your resignation.

If you fail to return immediately upon the expiration of your approved Company Leave, accept other employment while on a Company Leave (with certain exceptions), or make an application for unemployment benefits while on a Company Leave, you will no longer be considered on an approved Company Leave and your employment with the Company will end.

A Leave of Absence must be initiated through the Company's Leave and Disability Administrator. Appropriate documentation must be submitted to the Leave Administrator for approval. Thirty days' advance notice is required when the leave is "foreseeable."

Other Personal Leave

If you are a regular-status employee, you may request an unpaid leave if you have any other urgent or substantial personal reasons not already discussed in this section. A Personal Leave may be granted for a period not in excess of six consecutive months. An extension may be granted for up to an additional six consecutive months if the circumstances warrant. The maximum length of this leave, including extensions, is 12 consecutive months in combination with all other leaves, excluding a military leave. A return to your former or equivalent position and work location is generally guaranteed.

This leave is an unpaid absence of more than 10 consecutive workdays and cannot be taken on an intermittent or reduced schedule basis.

Paid time off (i.e., vacation, floating holiday and paid holiday) must be exhausted prior to going on unpaid Personal Leave.

Leave may not be used to cover a period of incarceration. Please refer to the Leave of Absence Conditions Standard. Violations of the Leave of Absence Conditions Standard may be subject to disciplinary action.

The approval of the leave is based on the merit of the request, your length of service, your performance, and the Company's business needs. This leave will not be granted to cover a period of incarceration or if the purpose for which it is requested may lead to your resignation. The Company may refuse to grant the leave if the request would cause undue hardship to the Company's operation.

If you fail to return immediately on the expiration of your approved Company Leave, accept other employment while on a Company Leave (with certain exceptions), or make an application for unemployment benefits while on a Company Leave, you will no longer be considered on an approved Company Leave and your employment with the Company will end.

A Leave of Absence must be initiated through your supervisor and if approved, your supervisor will complete the process with the Company's Leave and Disability Administrator. Appropriate documentation must be submitted to your supervisor and the Leave and Disability Administrator for approval. Thirty days' advance notice is requested.

Military Leave of Absence

Uniformed Services Employment and Reemployment Rights Act (USERRA)

A Military Leave of Absence will be designated as such for eligible employees for up to a cumulative of five years (additional time and provisions may be available under USERRA) for service in the uniformed services, which includes duty on a voluntary or involuntary basis.

Duty means:

- active duty;
- active duty for training;
- initial active duty for training;
- inactive duty training;
- full-time National Guard duty;
- time needed for examination to determine fitness for duty;
- state active duty for a period of 14 days or more;
- state active duty in response to a national emergency declared by the President under the National Emergencies Act;
- state active duty in response to a major disaster declared by the President;
- service as intermittent personnel in the Federal Emergency Management Agency; or
- funeral honors duty performed by National Guard or Reserve members.

Uniformed services means:

- the Armed Services, including:
  - Army and Army Reserve;
  - Navy and Naval Reserve;
  - Air Force and Air Force Reserve;
  - Marine Corps and Marine Corps Reserve; and
  - Coast Guard and Coast Guard Reserve;
- the Army National Guard when engaged in active or inactive duty training;
- the Air National Guard when engaged in active or inactive duty training;
- full-time National Guard duty;

- the commissioned corps of the Public Health Service;
- commissioned officer corps of the National Oceanic and Atmospheric Administration;
- system members of the National Urban Search and Rescue Response System (appointed under section 327 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act);
- Service as an intermittent disaster response appointee of the National Disaster Medical System when employees are activated under federal authority, or attending authorized training in support of a federal mission; or
- any other category of persons designated by the President in times of war or emergency.

Advance verbal and/or written notice to your supervisor and the Company's Leave and Disability Administrator is required (with few exceptions).

Re-Employment Rights

If you receive an honorable discharge from a uniformed service, you are entitled to re-employment rights and benefits provided that:

- cumulative length of all military service leave from the Company does not exceed five years (certain types of service in the uniformed services are exceptions to this five-year service limit); and
- applicable documentation and timing requirements are met.

You can access more information on the **Leave of Absence** page at mypgebenefits.com for additional details on Military Leave (select Time Off and Accommodations > Leave of Absence > Military Leave), including applicable documentation and timing requirements based on length of time off due to military service.

A Leave of Absence for uniformed service of any length must be initiated through the Company's Leave and Disability Administrator. Appropriate documentation must be submitted to the Leave Administrator, when applicable. Reasonable and practicable advance notice is required when the leave is "foreseeable" and greater than 30 days.

Supplemental Pay

From date of hire, you are eligible to receive a pay supplement for up to 17 workdays per year for reserve and active duty. To receive a pay supplement, you must provide a copy of your military orders, the military statement of earnings and certified expense statement related to the annual training or active duty to the Payroll Department within one month of your return to work. Please contact the Payroll Department for questions relating to the receipt of a pay supplemental.

Additional pay supplements may be available beyond 17 workdays if you are covered under the Emergency Active Military Leave of Absence policy. Please see "Emergency Active Military Leave of Absence" for more information.

Contract, agency, or Hiring Hall employees who are participating in reserve training or active duty can take time-off without pay.

Health Plan Coverage

If you leave your job to perform military service, you have the right to elect to continue your existing Company health care plan coverage for up to 24 months while in the military. The costs for your health plan coverage will change after the first three full calendar months. Contact PG&E's Benefits Service Center at **1-866-271-8144** for more information.

Emergency Active Military Leave of Absence

The Emergency Active Military Leave policy was enacted to reduce the adverse financial impact on employees activated for military duty in the time of a national emergency. The policy allows employees to receive pay supplements that are equivalent to their base pay minus taxable wages received from the military, and extended medical, dental and vision coverage for themselves and their eligible dependents. The policy was implemented for employees required to provide military service in support of a contingency operation under the terms of

Executive Order 13223 of September 14, 2001, Declaration of National Emergency by Reason of Certain Terrorist Attacks (and its amendments).

In order to receive pay supplements, you are required to provide the Payroll Department with a copy of your military orders, the military statement of earnings and certified expense statement in order to start receiving your supplemental pay during your Emergency Military leave; otherwise, the leave will remain unpaid. You will be required to provide a copy of your military earnings each month of your leave, as feasible, in order to continue to receive supplemental pay. Contact the Payroll Department for more information on this process.

You can access more information on the **Leaves of Absence** page at mypgebenefits.com > select Time Off and Accommodations > Leave of Absence > Military Leave, for additional details on Emergency Military Leave.

A Leave of Absence must be initiated through the Company's Leave and Disability Administrator. Appropriate documentation (copy of military orders or other supporting documentation issued by the Military) must be submitted to the Leave Administrator when requested and applicable (i.e., for period of service greater than 30 days). Reasonable and practicable advance notice is required when the leave is "foreseeable."

Spouses of Deployed Military Personnel (California employees only)

If you are the spouse of a deployed military member, you may take up to 10 days of an unpaid leave of absence while the service member is on leave from a military deployment. The military member must be deployed as a result of a military conflict.

A military member means a member of:

- the Armed Forces of the United States,
- the National Guard, or
- the Armed Forces Reserve Components.

PG&E extends this policy to employees who are registered domestic partners of deployed military members.

- To qualify for this leave, you must work at least a 20-hour per week schedule. Your leave must be taken concurrently with the leave of the service member. Some or all of this time may run concurrently with FMLA exigency leave, if you are eligible.

A return to your former or equivalent position and work location is generally guaranteed.

A Leave of Absence must be initiated through the Company's Leave and Disability Administrator. You must notify your supervisor and the Leave Administrator of your intent to take this leave within two days of receiving official notice of your military spouse/registered domestic partner's leave and must submit written documentation of their leave orders.

Union Business Leave

You may request an unpaid leave for the purpose of engaging in union business. The leave, if approved, is issued for the estimated time needed. The maximum length of the leave is not to exceed a total of:

- 72 consecutive months for members of IBEW,
- 24 consecutive months for members of ESC, or
- 12 consecutive months for members of SEIU.

Return to your previous position (or equivalent) is guaranteed only if you return to work within six months of the date on which your leave began. If you take a Union Business Leave, your medical, dental and vision coverage will terminate at the end of the month in which you go on leave.

If you return to work from a Union Business Leave that lasts longer than six-month, you will not be granted another Union Business Leave until you have worked for a period equivalent to the duration of the last continuous absence for union business.

Other Time Off

You may be eligible for time off for other reasons, including:

- Jury Duty
- Funerals
- Religious Observance
- Adoption
- Voting
- Family School Partnership Act (FSPA) and School Suspension Leave
- Victims of Violence
- Civil Air Patrol Leave
- Emergency Duty Leave and Volunteer Firefighter Training
- San Francisco Family Friendly Workplace Ordinance (SF FFWO)

"Company" Defined

Throughout this section of the Handbook, reference to "Company" means Pacific Gas and Electric Company.

Jury Duty

The Company recognizes jury duty as an important civic duty. You are eligible for time off with pay if you are a regular-status employee. If you are called for jury duty; and you are:

- a full-time employee, you will be granted the necessary time off with pay, or
- a part-time employee, you will be granted time off with pay for the number of hours you are scheduled to work during the basic workday and work week.

If you are not a regular-status employee, you may be granted time off without pay. If you have available sick time, you may use it. You must:

- advise your supervisor on the workday following receipt of notice that you are required to report for jury duty service and you may be required to provide receipt of such notice to your supervisor,
- report to work on non-court days and may be required to provide updates on the trial schedules and court appearances, and
- return to work if the dismissal from court occurs on your regular workday and the time allows you to work two hours or more before the conclusion of your regular work schedule.

Funerals

You are eligible for up to five total days of funeral leave if a member of your immediate family dies. You are eligible for up to three days of time off with pay if you are a regular-status employee. You may request to use sick/vacation/, floating holidays, if applicable, to use for the additional two unpaid days and to extend your funeral leave, if needed. An "immediate family member" is defined as:

- your spouse or registered domestic partner;
- your child (including step-children, children of your registered domestic partner, foster children, or children for whom you have been appointed legal guardianship; or a miscarriage);
- your parent (including foster parents, step-parents, parents-in-law, or parents of your registered domestic partner);
- your brother or sister (including half-, step- and foster brothers and sisters);
- your grandparent or grandparent-in-law, or those of your registered domestic partner;
- your grandchild;

- your son-in-law or daughter-in-law;
- your uncle or aunt; or
- another person with whom you have a relationship.

You may also request up to one full day off to attend the funeral of any other person to whom you may be reasonably deemed to owe respect.

If you are not a regular-status employee, you may be granted time off without pay.

Religious Observance

Requests for time off for religious observance should be approved unless there are overriding operational needs. Because our employee population is comprised of various faiths, employees may request and be granted one occasion of up to four hours of paid time off per calendar year for the purpose of religious observance. Visit mypgebenefits.com > Time Off and Accommodations > Vacations, Holidays, Sick Time and Other Time Off for more information.

Adoption

You may request up to a maximum of eight hours of time off with pay, if necessary, for court appearances in connection with each child adoption proceeding if you are a regular-status employee. Time may be taken in increments of one hour or more. If you are a part-time employee, you may be granted time off with pay for the number of hours you are scheduled to work on that day.

If you are not a regular-status employee, you may be granted time off without pay.

The Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA) and the Company also provide for unpaid and paid personal leaves of absence for time off related to the adoption of a child, including time off for child bonding. The Company provides an adoption assistance benefit of up to $2,000 for each child you adopt to help pay for adoption-related expenses. See “Personal Leaves of Absence” and “Adoption Expense Reimbursement Program” for more information.

Voting

If you do not have sufficient time outside of working hours to vote, you are entitled to paid time off, up to two hours if needed, to vote. You must notify your supervisor in advance of the election day if you wish to take this additional time off. Any approved time off will be taken either at the beginning or the end of your workday, whichever allows you the most time to vote.

Family School Partnership Act (FSPA) and School Suspension Leave

The Family School Partnership Act (FSPA) allows eligible employees to take time off from work to participate in school activities for their children who are in grades kindergarten through twelve or attending a licensed day care facility. Eligible employee may also take time off to find, enroll or reenroll their children in a school or with a licensed child care provider or to address a child care provider or school emergency, if applicable reasonable notice is given. To be eligible, you must be a parent (including stepparent, foster parent, or a person who stands in loco parentis to, a child), guardian or grandparent who has custody of a child enrolled in a California public or private school, kindergarten through grade twelve, or licensed child day care facility.

“Child care provider or school emergency” means that your child cannot remain in a school or with a child care provider due to one of the following:

- The school or child care provider has requested that the child be picked up, or has an attendance policy, excluding planned holidays, that prohibits the child from attending or requires the child to be picked up from the school or child care provider.
- Behavioral or discipline problems.
- Closure or unexpected unavailability of the school or child care provider, excluding planned holidays.

- A natural disaster, including, but not limited to, fire, earthquake, or flood.

You may take off a maximum of eight hours per month, up to a maximum of 40 hours in a calendar year. To accommodate employees who work an alternate work schedule, additional hours over the monthly maximum may be allowed. Part-time employees are allowed prorated hours based on their work schedules.

If both parents work for the Company at the same worksite, the FSPA covered absence would apply to the parent who gives notice first. However, the other parent may take the planned absence simultaneously for the same child and event, provided that he or she receives supervisor approval.

School Suspension Leave allows eligible employees to take time off from work to attend a portion of a school day in the classroom with his/her child pursuant to a request made by the child's teacher/school under Section 48900.1 of the California Educational Code (e.g., following the suspension of the student). The employee must be the parent or guardian of the child. Request for time off must be made 30 days in advance of the leave, or as soon as practicable, **before** the day of the event.

You must use paid time off (vacation or floating holidays; prescheduled, unanticipated, or unscheduled, as appropriate) before using any unpaid time off. If both parents work for the Company at the same worksite, the FSPA covered absence would apply to the parent who gives notice first. However, the other parent may take the planned absence simultaneously for the same child and event, provided that he or she receives supervisor approval.

IBEW-represented Office and Clerical employees, please refer to Pre-Review Committee (PRC) decision #11858 for provisions regarding the recording of FSPA as Unanticipated Vacation in increments less than four hours.

You must inform your supervisor and the **Company's Leave and Disability Administrator at 1-855-732-8217** at least two workdays in advance. You are required to provide verification of participation in the school activities. For more detailed information about FSPA/School Suspension Leave, go to mypgebenefits.com.

California Protection for Victims and Family Member of Victims

If you or a family member are a victim of a "qualifying act of violence", you may take paid or unpaid time off work.

"Qualifying act of violence" includes domestic violence, sexual assault, stalking, or an act, or pattern of conduct that includes any of the following:

- an individual causing bodily injury or death to another individual;
- an individual exhibiting, drawing, brandishing, or using a firearm, or other dangerous weapon, with respect to another individual; or
- an individual using or making a reasonably perceived or actual threat to use force against another individual to cause physical injury or death.

A "victim" means individuals directly subjected to any of the above, domestic violence, sexual assault, or stalking, but also those who have experienced other qualifying crimes or abuse, which includes serious bodily injury, threat of injury or death, and crimes resulting in the death of family member.

"Family member" means:

- Child, regardless of age, who is a biological, adopted, or foster child, stepchild, or legal ward, a child of a domestic partner, a child to whom the employee stands in loco parentis, or a person to whom the employee stood in loco parentis when the person was a minor.
- Parent who is a biological, adoptive, or foster parent, stepparent, or legal guardian of an employee or an employee's spouse or domestic partner, or a person who stood in loco parentis when the employee or the employee's spouse or domestic partner was a minor child.
- Spouse who is the person to whom the employee is legally married under the laws of any state, or a domestic partner of an employee as registered under the laws of any state or political subdivision.

- Sibling who is a biological, foster, or adoptive sibling, a stepsibling, or a half-sibling.
- Designated person, which is someone related by blood, such as an aunt or uncle, or someone who is the equivalent of a family member, such as a best friend. Time off for a designated person may be limited to one designated person in a 12-month period.

Leave may be taken to attend to the following:

- For you or your family member to obtain or attempt to obtain any relief, including, but not limited to, a temporary restraining order, restraining order, or other relief or services, to help ensure the health, safety, or welfare of the victim or his or her family member.
- Seek medical attention or psychological counseling related to an injury or experience from a crime or abuse.
- Participate in a civil, administrative, or criminal proceedings (such as court hearings), moving, or caring for a family injured because of a qualifying act of violence or whose family member experiences a qualifying act of violence.
- Obtain services from a domestic violence shelter, program, rape crisis center, or victim services organization or agency as a result of the crime or abuse.
- Participate in safety planning and take other actions to implement safety measures for you or your family member from future violence, including temporary or permanent relocation
- For jury service or to appear in court as a witness to comply with a subpoena or court order.
- To seek, get, or provide childcare or care to a dependent adult if the care necessary to keep the child or adult safe after an act of violence.
- To care for a family member recovering from injuries caused by violence

There is no service or hours worked requirements to be eligible for this leave.

You must provide your supervisor and the **Company's Leave and Disability Administrator at 1-855-732-8217** reasonable advance notice of your intention to take time off for reasons related to a qualifying act of violence unless advance notice is not feasible. The

Duration may be as needed (documentation or certification may be required) and for up to 12 weeks. If you are the family member of a living victim of violence but not the actual victim, you may take up to 10 days off work for these reasons, with the exception of relocation, which is for up to five days

If a position is eliminated, an employee has no greater right to reinstatement or to other benefits and conditions of employment than if the employee had been continuously employed (working) during the leave period. FMLA and CFRA may run concurrently with leave under this leave, as applicable. However, time off under this law does not create a right for an employee to take leave that exceeds the leave time allowed under or is in addition to the unpaid leave time permitted by the FMLA or CFRA.

IBEW and SEIU-Represented Employees may use sick, vacation, floating holidays, etc. to receive pay for any of the time off reasons described above. You may be eligible for benefits from the Voluntary Plan if you are unable to work due to medical reasons or if you require time away from work to care for a seriously ill family member.

ESC-Represented Employees may use incidental/capped sick time vacation, floating holidays, etc. to receive pay for any of the time off reasons described above. Capped Sick time, when used for more than 7 calendar days for the same reason, is a component of the STD policy and follows the same time frames and processes.

In certain circumstances, you may also be eligible for reasonable accommodations. Visit mypgebenefits.com > Time Off and Accommodations > Vacations, Holidays, Sick Time and Other Time Off for more information.

Civil Air Patrol Leave

If you are a volunteer member of the California Wing of the civilian auxiliary of the United States Air Force (Civil Air Patrol) and you have been directed to respond to an emergency operational mission of the California Wing of the Civil Air Patrol, you are eligible for a leave of absence if you have been employed by the Company at least 90 days immediately preceding the commencement to your leave. An eligible employee may take up to 10 days per year of paid or unpaid leave. Leave is limited to three days on any one occasion, but can be extended if authorized by the government entity that called for the mission and the Company agrees.

You may request to use available vacation and floating holidays (paid time subject to your supervisor's approval).

You need to give as much notice as possible to your supervisor and the **Company's Leave and Disability Administrator at 1-855-732-8217** of the start and end dates to your Civil Air Patrol leave. Certification from the proper Civil Air Patrol authority to verify the eligibility for the leave requested or taken is required. You may be denied the leave to be taken as Civil Air Patrol leave if the required certification is not provided within a reasonable timeframe. A return to your former or equivalent position and work location is generally guaranteed.

Emergency Duty Leave and Volunteer Firefighter Training

If you are performing emergency duty as a volunteer firefighter, a reserve peace officer, or emergency rescue personnel, you may be eligible for time off. An eligible employee may take time off as needed in order to perform this emergency duty. This statute does not apply to any public safety agency or provider of emergency medical services when, the employee's absence would hinder the availability of public safety or emergency services.

If you are a volunteer firefighter, a reserve peace officer, or emergency rescue personnel, you may also be eligible to take a temporary leave of absence for the purposes of engaging in fire, law enforcement, or emergency rescue training. An eligible employee may take up to an aggregate of 14 days per calendar year, when taken for the purpose of engaging in fire or law enforcement training.

"Volunteer firefighter" means a person registered as a volunteer member of a regularly organized fire department.

"Emergency rescue personnel" means any person who is an officer, employee, or member of a fire department or fire protection or firefighting agency of the federal government, the State of California, a city, county, city and county, district, or other public or municipal corporation or political subdivision of this state, or of a sheriff's department, police department, or a private fire department, whether that person is a volunteer or partly paid or fully paid, while he or she is actually engaged in providing emergency services.

You may request to use available vacation, floating holidays (time off is subject to your supervisor's approval).

If the need for time off is foreseeable, you must inform your supervisor and the **Company's Leave and Disability Administrator at 1-855-732-8217** of the start and end dates to your Civil Air Patrol leave at least five days in advance. If the need for time off is unforeseeable, you must inform your supervisor at the beginning or your workday or with as much advance notice as possible.

Berkeley Family Friendly and Environment Friendly Workplace Ordinance (BFFEFWO)

The Berkeley Family Friendly and Environment Friendly Workplace Ordinance (BFFEFWO*)* requires that an employee has the right to request a flexible or predictable work schedule, who is employed within the geographic boundaries of Berkeley, and the employer must respond in writing within 21 days to any request for a flexible or predictable work schedule. For more information go to: https://cityofberkeley.info/BFFEFWO/ or mypgebenefits.com

San Francisco Family Friendly Workplace Ordinance (SF FFWO)

This Ordinance provides for employees who are headquartered in the City or County of San Francisco the opportunity to request a temporary flexible or predictable work schedule.

If you are a Management, Administrative & Technical, or ESC-represented employee headquartered in San Francisco, who has been employed by the company for six months, and work at least 8 hours per week, you are eligible to request a temporary flexible or predictable work schedule.

The ordinance requires employers to engage in a discussion with an employee to determine whether the company is able to accommodate the alternate work schedule request. Employers have the right to decline a request based on business needs.

Requests will be considered for up to 12 weeks in a 12-month rolling calendar period. Employees may make two requests a year as per the Ordinance — for a total of 12 weeks in a 12-month rolling calendar timeframe.

To request a temporary flexible or predictable work schedule, your first step is to have a discussion with your supervisor. Secondly, you must complete the SF FFWO Temporary Flexible or Predictable Work Schedule Request Form and submit it to the Stay at Work/Return to Work team. Additional information can be obtained by visiting the **San Francisco Family Friendly Workplace Ordinance (SFFWO)** section of mypgebenefits.com, under the Time Off and Accommodations tab.

San Francisco Public Health Emergency Leave (SF PHEL)

Effective October 1, 2022, employees who work on site or telework in San Francisco are eligible for up to 40 hours of sick time for time away from work due to a public health emergency, such as a pandemic. Employees who are considered members of a vulnerable population are eligible for time off for air quality emergencies. Effective January 1, 2023, and every January 1 going forward, employees who work on site or telework in San Francisco will be eligible for up to 80 hours of sick time for the same reasons stated above. "Vulnerable" employees are defined as persons who have been diagnosed with heart or lung disease, have respiratory problems, are pregnant, or are age 60 or older) and primarily work outdoors. Employees may use PHEL if they are unable to work due to any of the following:

1. The recommendations or requirements of an individual or general federal, state, or local health order related to the public health emergency;
2. The employee has been advised by a healthcare provider to isolate or quarantine;
3. The employee is experiencing symptoms of and seeking a medical diagnosis, or has received a positive medical diagnosis, for a possible infectious, contagious, or communicable disease associated with the public health emergency;
4. The employee is caring for a family member who is subject to an order described in #1, has been advised as described in #2, or is experiencing symptoms as described in #3;
5. The employee is caring for a family member if the school or place of care of the family member has been closed, or the care provider is unavailable due to the public health emergency; or
6. An air quality emergency, if the employee is a member of a vulnerable population and primarily works outdoors.

Work/Life Benefits

This section covers work/life benefits that are available to eligible employees of the Company. Eligible employees are defined in the description of each program. These benefits include:

- Adoption Expense Reimbursement Program: The program provides employees up to $2,000 for reimbursement of eligible expenses related to the adoption of children under the age of 18, including stepchildren.
- Commuter Transit Program: Provides you with the opportunity to purchase transit passes and pay for certain parking expenses with before-tax contributions.
- Employee Discount: Pacific Gas and Electric Company offers its employees a 25% discount on Pacific Gas and Electric Company-supplied gas for an employee's primary residence (domestic use only). The discount for PG&E-supplied electric service is a 25% discount on the full Tier 1 rate usage plus 25% of the charges for all usage in excess of baseline calculated using the Tier 2 rate.
- Legal/Financial Services (Carelon Behavioral Health): Legal/Financial Services are available through the Company's Employee Assistance Program (EAP). If legal advice is needed, you can speak with a licensed attorney by telephone or in person. If financial advice is needed, you can speak with a financial coach by telephone.
- Enhanced Family Support Program: PG&E partnered with Bright Horizons (BH) to help you manage your many work, family and personal responsibilities.
- Tuition Refund Program: The Tuition Refund Program allows you the opportunity to enroll in approved courses to support your educational goals. These approved courses are designed to assist you in performing your current duties in the most productive manner possible and to help enable you to assume new duties in the future.
- Work/Life Program (Carelon Behavioral Health): The Work/Life program, administered by Carelon Behavioral Health, provides information and assistance in locating quality child care or elder care services locally and nationwide. Additional Work/Life resources are available.

Adoption Expense Reimbursement Program

Pacific Gas and Electric Company, and PG&E Corporation and its covered affiliates (referred to collectively as the "Company" in this section), offers the Adoption Expense Reimbursement program. The PG&E Adoption Expense Reimbursement Program provides employees up to $2,000 for reimbursement of eligible expenses related to the adoption of children under the age of 18, including stepchildren. There is no limit on the number of adoptions eligible for reimbursement per employee. However, if both parents are Company employees, only one employee can apply for reimbursement for any single adoption. In addition, if one parent is a Company employee and his/her spouse/registered domestic partner works for a different employer who also offers an adoption expense program, the programs will be coordinated so that the combined reimbursement from both employers will not exceed 100% of the total allowable expenses incurred.

The Adoption Expense Reimbursement Program is a Company practice and is not subject to employee benefits regulations including, but not limited to, ERISA.

Eligibility

All employees who have completed six months of employment and who are on active payroll or are on an approved leave of absence when the adoption is made final are eligible to participate in the Adoption Expense Reimbursement Program. The Adoption Expense Reimbursement Application must be submitted within one year of the date of the final order.

You and your spouse/registered domestic partners and dependents are not eligible for the Adoption Expense Reimbursement Program if you are a contract or agency worker, a Hiring Hall employee, or a retired employee. Intermittent employees and other temporary employees who are not expected to become regular employees are also not eligible for coverage.

What the Program Covers

Eligible expenses include legal, court, adoption agency and placement fees, medical expenses for the adopted child which are not covered by a medical plan, and transportation expenses associated with picking up the child. Eligible expenses include surrogacy arrangements once a point has been reached in the surrogacy-related legal process when the employee's parental role and responsibility has been affirmatively recognized or ordered by the court. Eligible expenses for the income tax credit may differ (see "Income Tax Credit" below).

Income Tax Credit

You may be able to take advantage of both an income tax credit and the Adoption Expense Reimbursement Program for qualified adoption expenses paid or incurred by you in connection with the adoption of an eligible child. However, you may not claim both an income tax credit and a reimbursement for the same expense. Qualified adoption expenses generally include adoption fees, court costs, attorney's fees, and traveling expenses.

Check with your tax advisor for more details.

How to Apply

Before submitting your Adoption Expense Reimbursement Application, you may want to consult with your tax advisor to determine how to take maximum advantage of both the tax credit and the reimbursement program.

You can access a copy of the Adoption Expense Reimbursement Application online at mypgebenefits.com > Mental Health and Family Support > Adoption Resources. Alternatively, you can call PG&E Benefits Service Center at **1-866-271-8144** to request the application.

Completed applications should be sent via Company mail to: PG&E Benefits Service Center P.O. Box 9920 Providence, RI 02940-4020.

Once your application has been received and approved, your application will be processed within four weeks. The amount of your reimbursement will be reflected in your regular paycheck. Current laws require that adoption benefits in the form of cash assistance are subject to the state and federal income tax regulations.

Claims and Appeals

Claims

If you have a claim regarding a reimbursement relating to expenses, fees or other claims relating to the Adoption Expense Reimbursement Program, you can file a claim for benefits with the Benefits Department by writing to:

Pacific Gas and Electric Company
Benefits Department
Plan Administrator Claims
300 Lakeside Drive
Oakland, CA 94612

No special form or format is required in submitting a written claim for benefits; you may submit written comments, documents, records and other information relating to your claim. Please note, however, that it is the obligation of the Benefits Department to administer the Plan consistently in accordance with the provisions of the Plan.

If the Benefits Department denies your claim, you will receive a written response.

The Benefits Department will respond to you within a reasonable period of time, but not more than 60 days after the Benefits Department's receipt of your claim unless, due to special circumstances, the Benefits Department

requires additional time to respond, up to another 60 days. If an extension of time is required, the Benefits Department will notify you within the initial 60 days of the special circumstances requiring the extension and when the Benefits Department expects to render its decision.

Appeals

If you are not satisfied with the Benefits Department's decision, you may submit a written appeal to the Employee Benefit Appeals Committee (EBAC), stating the reasons for your appeal and enclosing all supporting documentation. Please note: Your appeal to EBAC must be received by EBAC within 90 days of your receipt of notice that your claim has been denied by the Plan Administrator.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
EBAC Appeals
300 Lakeside Drive
Oakland, CA 94612

No special form or format is required in submitting a written appeal; you may submit written comments, documents, records and other information relating to your claim. You may also request, free of charge, reasonable access to, or copies of, all documents, records and other information relevant to your claim for benefits. The EBAC review of your appeal will take into account all comments, documents, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered at the initial benefit determination.

You will receive a final ruling from EBAC within a reasonable period of time, but not more than 60 days after EBAC's receipt of your appeal unless, due to special circumstances, EBAC requires additional time to respond, up to another 60 days. If an extension of time is required, EBAC will notify you within the initial 60 days of the special circumstances requiring the extension and when EBAC expects to render its decision.

If EBAC denies your appeal, you will receive a written response.

Commuter Transit Program

Pacific Gas and Electric Company, PG&E Corporation and its covered affiliates (referred to collectively as the "Company" in this section), offers its employees the opportunity to purchase transit products and passes, and pay for certain parking expenses with before-tax contributions through the Commuter Transit Program. The program is administered by a third-party vendor. For additional information about the program, you can contact the PG&E Benefits Service Center at **1-866-271-8144**. Information is also available online at mypgebenefits.com > Financial Health > Commuter Transit Program.

The Commuter Transit Program is a Company practice and is not subject to employee benefits regulations including, but not limited to, ERISA.

Eligibility

All employees of the Company except temporary employees or contract, agency, leased or retired employees are eligible to participate in the Commuter Transit Program. In order to participate, you must enroll online. To enroll online, access PG&E's Benefits Portal available through PG&E@Work For Me.

Benefits

You must elect to participate or change your participation no later than the fifth calendar day of any month in order to receive or modify commuter benefits for the following month. If you select recurring orders, the options you elect will remain the same from month to month until you change or cancel your order.

The IRS rules that govern the program have monthly before-tax maximums. Visit irs.gov for more information.

Eligible commuter expenses include the costs for:

- BART tickets,
- Muni Fast Passes,
- Passes, vouchers, or tickets for other subways, metros, buses, trains or ferries,
- Cash value placed on a Clipper card,
- Vanpooling in a qualified commuter highway vehicle, and
- Parking at or near your company work location or where you board a transit system.

Ineligible expenses include, but are not limited to, costs for:

- Tolls
- Carpools
- Taxis or limousine services
- Parking tickets
- Cost of parking at or near your home or residence
- Gasoline
- Bike rentals or bike sharing

Forfeitures

Parking claims for reimbursement not submitted within 12 months of the date incurred are not eligible for reimbursement. Under IRS regulations, you may only be reimbursed for eligible expenses incurred before your retirement or termination date. If you retire or your employment with the Company terminates, voluntarily or involuntarily, you have 90 days after the date employment ends to submit your claim for eligible expenses incurred while you were an active employee. Any funds left in your account after the claims filing deadline will be forfeited. In addition, unused balances of specific commuter products are considered forfeited once you retire or your employment with the Company terminates. Completed transit orders are considered non-refundable.

Employee Discount

Pacific Gas and Electric Company offers its employees a 25% discount on Pacific Gas and Electric Company-supplied gas for an employee's single-family primary residence (domestic use only). The discount for PG&E supplied-electric service is a 25% discount on the full Tier 1 rate usage, plus 25% of the charges for all usage in excess of baseline calculated using the Tier 2 rate. There is no employee discount for non-tiered electric rates.

You Must Call

It is your responsibility to contact the **Contact Center at 1-800-743-5000** to request the rate. The employee rate is not automatic.

The Employee Discount is a Pacific Gas and Electric Company practice and is not subject to employee benefits regulations including, but not limited to, ERISA.

Eligibility

You are eligible for this discount if you are an employee of Pacific Gas and Electric Company and you have completed six months of continuous service and attained regular status. (This includes employees on Military Leave.)

In order to receive this benefit, you must:

- live within the Pacific Gas and Electric Company's service territory, and
- have the service in your name at your primary residence.

An employee is eligible to receive employee rates only at the employee's principal residence. However, a General Construction employee or other employee similarly required to be away from his/her principal residence on PG&E work assignment is eligible for the discount while occupying a second residence.

Employees who are eligible for the discount under residential single-family rate, and who have two separate meters providing residential service to their principal residence, may receive the employee rate discount on both services. For example, one meter serves the home and the second meter serves a domestic well pump. Where the meter serves more than one residence, such as a duplex, employee rates are not applicable.

Where two or more PG&E Company employees share the same, single-metered, primary residence, only one employee rate discount may be claimed for that residence. Employees residing in such a shared residence who are not the customer of record for that residence may not apply for an employee discount at an alternate residence, which is not their primary residence.

You are also eligible for this discount if you are a qualified pensioner of Pacific Gas and Electric Company. A qualified pensioner is any employee who worked for the Company and was age 55 or greater on the last day of their employment. If you worked for the Company, but ended your employment before age 55, you are not eligible for the service discount–even if you are eligible for pension benefits. Employees who retire from PG&E Corporation are not entitled to the employee discount.

You are not eligible for benefits if you are a summer hire, summer technical intern, contract employee, agency employee, hiring hall employee, or leased employee. Intermittent employees and other temporary employees who are not expected to become regular employees are also not eligible for coverage. In addition, you are not eligible if you are an employee of:

- any subsidiary of Pacific Gas and Electric Company;
- any affiliated company; or
- PG&E Corporation or any affiliated company of PG&E Corporation.

When an employee's employment with the Company is terminated for a reason other than retirement, the Human Resource department shall immediately notify Customer Billing, which shall remove the employee's residence from residential employee rates effective on the date employment is terminated. This includes termination of employment with the Company prior to rehire as an employee of the PG&E Corporation or one of its non-utility subsidiaries.

Requesting the Discount and Change of Residence

You must call the **Customer Contact Center at 1-800-743-5000** to:

- Request the discount for the first time, or
- Transfer the discount to a new location.

Legal/Financial Services (Carelon Behavioral Health)

Pacific Gas and Electric Company, and PG&E Corporation and its covered affiliates (referred to collectively as the "Company" in this section), offer Legal/Financial Services through the Company's Employee Assistance Program (EAP), administered by Carelon Behavioral Health.

If legal advice is needed, you can speak with a licensed attorney by telephone or in person. If financial advice is needed, you can speak with a certified financial advisor by telephone.

Common legal topics include:

- Alimony/Child Support
- Adoption
- Living Wills
- Powers of Attorney

- Foreclosures

Common financial topics include:

- Savings Strategies
- Debt Management
- Retirement Planning
- Credit Scores

Eligibility

Legal/Financial Services are available to all Company employees, their spouses/registered domestic partners, eligible dependents and household members.

You and your spouse/registered domestic partner and dependents are not eligible for this benefit if you are a contract or agency worker, a hiring hall employee, or a retired employee. Intermittent employees and other temporary employees who are not expected to become regular employees are also not eligible for coverage.

Cost

Legal Services

After your initial call to Carelon Behavioral Health, if further legal services are needed, you can be referred to an attorney in private practice in your area who handles your kind of legal problem. The attorney will provide a telephonic or face-to-face consultation at no cost to you. If legal representation is needed beyond the initial consultation, and you decide to hire the attorney for further services, you will receive a discount from the usual hourly rate.

Financial Services

After your initial call to Carelon Behavioral Health, you will be referred to a financial coach for assistance. The advisor will provide a telephonic consultation at no cost to you and a discount on any additional services.

How to Use Legal/Financial Services

To request legal or financial services, simply call the **EAP Hotline at 1-888-445-4436** or visit th.carelonwellbeing.com/pge. Some exclusions apply (see below).

Exclusions

The Carelon Behavioral Health-referred attorneys cannot provide legal services for these four matters:

- Employment Issues — Potential legal disputes between employees and employers.
- Corporate Law — Advice on any business or commercial enterprise belonging to you, your spouse or registered domestic partner.
- Second Opinions — Advice on how another attorney is handling a legal matter for you.
- Third-Party Advice — Advice on a question involving someone other than you, your spouse/registered domestic partner, dependents, or household members.

Enhanced Family Support Program

PG&E partnered with Bright Horizons (BH) to help you manage your many work, family and personal responsibilities. BH's Enhanced Family Support Program includes:

- Waitlist preference at select BH centers and tuition discounts at partner centers such as KinderCare.

- Waived membership fee and free basic background checks for premium accounts on Sittercity–giving you access to sitters for children, virtual sitting, pet care and housekeeping services.
- Discounts on a local, high-touch placement service of trained, screened nannies for full-time child care.
- Exclusive discounts on tutoring, test prep, and enrichment classes, plus small-group learning pods.
- Visit clients.brighthorizons.com/PGE for additional information and details on the BH Enhanced Family Support Program.

Tuition Refund Program

The Pacific Gas and Electric Company, and PG&E Corporation and its covered affiliates (referred to collectively as the "Company" in this section), offers the Tuition Refund Program for approved courses outside of work. The Tuition Refund Program (TRP) allows you the opportunity to enroll in approved courses. These approved courses are designed to assist you in performing your current duties in the most productive manner possible and/or to help enable you to assume new duties in the future.

The Tuition Refund Program is a Company practice and is not subject to employee benefits regulations including, but not limited to, ERISA.

Note: The information included in this section does not reflect all program guidelines. To view the Tuition Refund Program guidelines (Standard), refer to **Tuition Refund Program** on mypgebenefits.com > Financial Health > Tuition Refund Program.

Contact Information

For general program information or questions regarding submitted applications, contact EdAssist, PG&E's Tuition Refund Program Administrator.

- Tuition Refund Helpline: 1-888-718-2235 between the hours of 5 a.m.–5 p.m., Pacific time.
- If you have a question that is not addressed in the TRP Standard, **email** the Tuition Refund Program office at: **PGETuition@pge.com**.

Work/Life Program (Carelon Behavioral Health)

The Company offers the Work/Life Program. The Company-sponsored Work/Life program, administered by Carelon Behavioral Health, provides information and assistance in locating quality child care or elder care services locally and nationwide. In addition, other Work/Life resources are available.

Contact

Call 1-888-445-4436 or visit https://th.carelonwellbeing.com/pge to access Work/Life services

Eligibility

The Work/Life program is available to all Company employees, their dependents, and their household members.

You are not eligible for this program if you are a contract or agency worker, a hiring hall employee or a retired employee.

What the Program Provides

Some of the Work/Life services provided include:

- Telephone counseling to help identify the type of dependent care assistance you need;
- Printed educational materials to guide you in making appropriate dependent care decisions;

- Referrals that have confirmed availability and openings to state-licensed family home day care centers, child care centers, nursery schools, private and public schools, and college and vocational schools; and
- Referrals to nationwide resources on housing, health care, insurance, aging, and financial information for elderly parents.

How to Use the Work/Life Program

To request Work/Life referral services, simply call the **EAP Hotline at 1-888-445-4436** or visit h.carelonwellbeing.com/pge. This service is available 24 hours a day, 7 days a week.

Rules, Regulations & Administrative Information

This section describes a number of regulations that apply to the benefits described in this Handbook and provides some administrative details about the plans.

Not all of the plans or benefits in the Handbook are subject to all of the same laws. For example, some plans are subject to the Employee Retirement Income Security Act of 1974 (ERISA) while others are not.

The plans and all rights hereunder are governed by and construed, administered, and regulated in accordance with the provisions of applicable federal law, and, to the extent not preempted by ERISA (as applicable), the laws of the state of California, without giving effect to its conflicts of laws provision. The plans may not be interpreted to require any person to take any action, or fail to take any action, if to do so would violate any applicable law.

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Plan Amendment and Termination

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

Any change to the plans or the termination of any plans will not affect the benefits payable to plan members before the date the plan was changed or ended, but such change may result in reduced levels of benefits or benefit coverage, or higher levels of employee contributions, after the effective date of any such change.

"Company" Defined

Throughout this section, unless otherwise stated, reference to "Company" or "PG&E" means Pacific Gas and Electric Company. For plans sponsored by PG&E Corporation, reference to "Company" or "PG&E" means PG&E Corporation.

In the event that the Company terminates a plan for any reason without replacing it, you will be given notice.

The plans may also be terminated by judicial action if the Company is bankrupt or insolvent, or upon complete dissolution, merger, consolidation or reorganization without provision by a successor-company for continuation of the plans.

Plan Administration

The PG&E Corporation Employee Benefit Committee is the Plan Administrator and is responsible for the overall administration of the plans. This committee has the sole power and discretionary authority to establish, and from time-to-time revise, such rules and regulations as may be necessary to administer the plan in a nondiscriminatory manner for the exclusive benefit of participants and all other persons entitled to benefits under the plans. This committee delegates to the most senior leader of Human Resources of PG&E Corporation and assigned staff the authority to interpret, implement, and revise rules and regulations as necessary to administer the plans in a proper and nondiscriminatory manner. Staff is also responsible for overseeing participant recordkeeping, accounting, reporting, and receipt and disbursement of plan assets, if any.

The Plan Administrator has the discretionary authority to interpret and construe the terms of the plans, to resolve any conflicts or discrepancies between documents and to establish rules that are necessary or desirable for the administration of the plans.

Your Rights Under ERISA

Participants in the plans in this Handbook that are subject to the Employee Retirement Income Security Act of 1974 (ERISA) are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may charge a reasonable fee for the copies. You may also review all official plan documents, during normal business hours, in the Benefits Department.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage (including health care flexible spending account coverage) for yourself, spouse and/or eligible dependents if there is a loss of coverage under the plan as a result of a qualifying event under

COBRA. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the plan now.

  If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Health Information Privacy and Data Security

The Pacific Gas and Electric Company and its health plan partners are committed to protecting the privacy and confidentiality of the health information for eligible participants (including eligible employees, retirees and surviving spouses, and their eligible dependents) that is created or received in the administration of The Pacific Gas and Electric Company Health Care Plan for Active Employees and The Pacific Gas

Please Read This Carefully

This section describes how medical information about you may be used and disclosed and how you can obtain access to this information.

and Electric Company Health Care Flexible Spending Account Plan (collectively, "Health Plans").

To receive more information about the Health Plans' health information privacy practices or HIPAA rights, or if you have any questions about the HIPAA Notice, you may contact the Pacific Gas and Electric Company Plan Administrator, PG&E Benefits Department, 300 Lakeside Drive, Oakland, CA 94612.

HIPAA Notice of Health Information Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This version of the notice is effective February 16, 2026. Please review it carefully.

This notice is required by the Health Insurance Portability and Accountability Act ("HIPAA") and is intended to describe to the extent applicable to you how the Pacific Gas and Electric Company Health Care Plan for Active Employees, the Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, and the Pacific Gas and Electric Company Health Care Flexible Spending Account Plan (collectively, "Health Plans"), and the various health plan vendors that administer these Health Plans (for example, Anthem Blue Cross) will protect your health information. This notice also describes your rights to access and control your protected health information, including special protections for certain records containing substance use disorder information.

"Health information" for this purpose means information that identifies you and either relates to your physical or mental health condition or the provision of health care to you, or relates to the payment of your health care expenses. This individually identifiable health information is known as "protected health information" ("PHI"). Your PHI will not be used or disclosed by the Health Plans without a written authorization from you, except as described in this notice or as otherwise permitted by federal or state health information privacy laws. Please note that your personal physician or other health care facilities (for example, hospitals or health clinics) where you may receive health care or treatment may have different policies, procedures or notices regarding the physician's or health care facility's use or disclosure of PHI that they may have created. These health care providers and any health plan insurer will separately notify you regarding their health information policies or procedures.

SUMMARY

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask the Health Plans to limit the information shared
- Get a list of those with whom the Health Plans have shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that the Health Plans use and share information to:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market Health Plan services and sell your information

Our Uses and Disclosures

The Health Plans may use and share your information to:

- Help manage the health care treatment you receive
- Run the Health Plans' organizations
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Our Uses and Disclosures of Your Substance and Alcohol Use Disorder Records

If you receive treatment for a substance use disorder ("SUD") from a health care provider or program that is subject to the federal privacy rules under 42 CFR Part 2 ("Part 2") and give your consent to your health care provider for your Part 2 treatment records to be used and disclosed for purposes of treatment, payment, or health care operations, the Health Plans may rely on such consent for their own future uses and disclosures of such records for treatment, payment, or health care operations under the Health Plans. In addition, the Health Plans may not disclose your SUD records that are subject to Part 2, or provide testimony relaying the content of such records, for use in a civil, criminal, administrative, or legislative proceeding against you unless the Health Plans have your written consent, or the Health Plans have a court order accompanied by a subpoena or other legal requirement compelling disclosure issued after notice and an opportunity to be heard is provided to you or the Health Plans, as required under Part 2.

Details

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of the Health Plans' responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information the Health Plans have about you—except for psychotherapy notes; information intended for use in a civil, criminal or administrative proceeding; or any information to which access is otherwise prohibited by law. Contact the PG&E Benefits Service Center to request this information. Ask your health plan(s) how to do this.
- The Health Plans will provide a copy or a summary of your health and claims records, usually within 30 days of your request. A single, 30-day extension is allowed if the Health Plans cannot comply by the initial deadline. In limited situations, the Health Plans may say "no" to your request, but will tell you why in writing and may charge a reasonable, cost-based fee.

Ask the Health Plans to correct health and claims records

- You can ask your health plan(s) to correct your health and claims records if you think they are incorrect or incomplete. Ask your health plan(s) how to do this.
- The Health Plans may say "no" to your request, but will tell you why in writing within 60 days. A single, 30-day extension is allowed if the Health Plans cannot comply by the initial deadline.

Request confidential communications

- You can ask to be contacted in a specific way (for example, home or office phone) or to send mail to a different address.
- The Health Plans will consider all reasonable requests, and must say "yes" if you tell your health plan(s) you would be in danger otherwise.
- To request confidential communications, make your request in writing to:

  Pacific Gas and Electric Company
  HIPAA Privacy Official
  Email: pgeprivacy@pge.com
  Phone: 1-866-271-8144

- The Health Plans will make every attempt to accommodate all reasonable requests. Your request must specify how or where you want to be contacted.

State privacy rights

You may have additional privacy rights under state laws, including rights in connection with mental health and psychotherapy reports, pregnancy, HIV/AIDS-related illnesses, and the health treatment of minors.

Ask the Health Plans to limit what the Health Plans use or share

- You can ask the Health Plans not to use or share certain health information for treatment, payment, or Health Plans' operations.
- The Health Plans are not required to agree to your request, and may say "no" if it would affect your care.

Get a list of those with whom the Health Plans have shared information

- You can ask for a list (accounting) of the times the Health Plans have shared your health information for six years prior to the date you ask, who the Health Plans shared it with, and why.
- The Health Plans will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked the Health Plans to make). The Health Plans will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time by calling the PG&E Benefits Service Center at 1-866-271-8144, even if you have agreed to receive the notice electronically. The Health Plans will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- The Health Plans will make sure the person has this authority and can act for you before taking any action.

File a complaint if you feel your rights are violated

- You can complain if you feel the Health Plans have violated your rights by contacting: Pacific Gas and Electric Company

  HIPAA Privacy Official
  Email: pgeprivacy@pge.com
  Phone: 1-866-271-8144

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:
  - Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
  - Calling 1-877-696-6775; or

- Visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

- The Health Plans will not retaliate against you for filing a complaint. The complaint should generally be filed within 180 days of when the act or omission complained of occurred.

Your Choices

For certain health information, you can tell the Health Plans your choices about what the Health Plans share. If you have a clear preference for how the Health Plans share your information in the situations described below, talk to the Health Plans. Tell the Health Plans what you want done, and the Health Plans will follow your instructions.

In these cases, you have both the right and choice to tell the Health Plans to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell the Health Plans your preference—for example if you are unconscious—the Health Plans may go ahead and share your information if the Health Plans believe it is in your best interest. The Health Plans may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, the Health Plans never share your information unless you give the Health Plans written permission:

- Marketing purposes
- Sale of your information

The Health Plans' Uses and Disclosures

How do the Health Plans typically use or share your health information?

The Health Plans typically use or share your health information in the following ways:

Help manage the health care treatment you receive

The Health Plans can use your health information and share it with professionals who are treating you.

Example: A doctor sends your health plan(s) information about your diagnosis and treatment plan so your health plan(s) can arrange additional services.

Run the Health Plans' organizations

- The Health Plans can use and disclose your information to run the Health Plans' organizations and contact you when necessary.
- The Health Plans are not allowed to use genetic information to decide whether the Health Plans will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: The Health Plans use health information about you to develop better services for you.

Pay for your health services

The Health Plans can use and disclose your health information as the Health Plans pay for your health services.

Example: The Health Plans share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

The Health Plans may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with the Health Plans to provide health benefits, and the Health Plans provide your company with certain statistics to explain the premiums the Health Plans charge.

How else can the Health Plans use or share your health information?

The Health Plans are allowed or required to share your information in other ways— usually in ways that contribute to the public good, such as public health and research. The Health Plans have to meet many conditions in the law before your information can be shared for these purposes. For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

The Health Plans can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

The Health Plans can use or share your information for health research.

Comply with the law

The Health Plans will share information about you if local, state or federal laws require it, including with the Department of Health and Human Services if it wants to see that the Health Plans are complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- The Health Plans can share health information about you with organ procurement organizations.
- The Health Plans can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

The Health Plans can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

The Health Plans can share health information about you in response to a court or administrative order, or in response to a subpoena, warrant, discovery request, or other forms of lawful due process.

The Health Plans' Responsibilities

- The Health Plans are required by law to maintain the privacy and security of your protected health information. This includes any additional protections under Part 2 for SUD records.
- The Health Plans will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- The Health Plans must follow the duties and privacy practices described in this notice and give you a copy of it.

- The Health Plans will not use or share your information other than as described here unless you tell a Health Plan it can in writing. If you tell a Health Plan it can use or share your information, you may change your mind at any time. Let the Health Plans know in writing if you change your mind.

For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/ index.html.

Changes to the Terms of this Notice

The Health Plans can change the terms of this notice, and the changes will apply to all information the Health Plans have about you. The new notice will be available upon request on the Health Plans' websites, and a copy will be mailed to you unless you had agreed to receive the notice electronically, or unless you are able to receive electronic information at your worksite.

Forfeiture of Unclaimed Benefit Payments

If you receive, or are entitled to receive, a benefit payment from one of the self-insured health plans and the Claims Administrator cannot locate you, the payment will be returned to the Company or, if paid from one of the Company's trust funds, the appropriate trust. If, after three years from the date on which the benefit is paid or became payable, you have not accepted the payment or corresponded with the Claims Administrator or Trustee in writing concerning the benefit payment, the payment will be forfeited to the Company's operating general assets or trust that issued the payment. For additional information on plan funding, see "Funding" in the table that describes "The Pacific Gas and Electric Company Health Care Flexible Spending Account Plan."

If the Plan Administrator is unable to locate a Participant entitled to benefits payable from the Pacific Gas and Electric Company Retirement Plan ("Retirement Plan") or the PG&E Corporation Retirement Savings Plan for Union-Represented Employees ("RSP") after three years and after reasonable efforts have been made to do so, the Participant's benefit under the Plan will be forfeited and used to offset future employer contributions. If a proper claim is subsequently presented, the Participant's benefit will be reinstated. For additional information, see "PG&E Corporation Retirement Savings Plan for Union-Represented Employees (formerly called the Pacific Gas and Electric Company Savings Fund Plan for Union-Represented Employees)" , and "The Pacific Gas and Electric Company Retirement Plan."

Rescission in Event of Fraud

Any act, practice, or omission by a plan participant that constitutes fraud or an intentional misrepresentation of material fact is prohibited by the plan, and the plan may rescind coverage retroactively as a result. Any such fraudulent statements, including on plan enrollment forms and in electronic submissions, may invalidate any payment or claims for services and may be grounds for rescinding coverage.

Nonalienation of Benefits

No benefit, right, or interest of any Eligible Employee or Eligible Dependent under the plans shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities, or other obligations of such person, except as otherwise required by law. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute, or levy upon, or otherwise dispose of any right to benefits payable hereunder shall be void. Notwithstanding the foregoing, the plans may choose to remit payments directly to health care providers with respect covered services, if authorized by the Participant, but only as a convenience to Participants. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under the plans and have no right to receive benefits from the plans or to pursue legal causes of action on behalf of (or in place of) Participants under any circumstances.

Facility of Payment

If any benefit from one of the self-insured health plans is payable to the estate of a Participant or to a dependent who is a minor or otherwise not competent to give a valid release, the self-insured health plan may pay the

benefits to any relative or other person or persons whom the plan determines to have accepted competent responsibility for the care of the Participant or the dependent or for administration of the Participant's estate. Any payment made by a self-insured health plan in good faith pursuant to this provision fully discharges the plan and the Company to the extent of such payment.

Administrative Information

This section contains administrative details, such as official plan names and numbers and contact information for each plan subject to ERISA.

The Pacific Gas and Electric Company Health Care Plan for Active Employees

Name and Address of Employer/Plan Sponsor	Pacific Gas and Electric Company 300 Lakeside Drive Oakland, CA 94612
Employer Identification Number	Pacific Gas and Electric Company: 94-0742640
Participating Employers	Pacific Gas and Electric Company PG&E Corporation PG&E Corporation Support Services II, Inc.
Plan Name	The Pacific Gas and Electric Company Health Care Plan for Active Employees
Plan Number	541
Plan Type	See "Plan Directory" below.
Plan Year	1/1–12/31
Plan Administrator	The Employee Benefit Committee (EBC) of PG&E Corporation c/o Pacific Gas and Electric Company Benefits Department 300 Lakeside Drive Oakland, CA 94612
Plan Trustee, Insurance Issuer and/or Third-Party Administrator	See "Plan Directory" below.
Discretionary Authority	The Plan Administrator has oversight responsibility for the administration of the Plan which includes maintaining records, and making rules, computations, interpretations and decisions that may be necessary for administration of the Plans. The Plan Administrator has the discretionary authority to interpret, construe, and define the terms of the Plan and may advise the Plans' Claims Administrators of such interpretations, constructions and definitions.
Agent for the Service of Legal Process	If you wish to take legal action after exhausting the applicable claims and appeals procedures, a lawsuit may be served on the ERISA Plan Administrator. Service should be directed to: Brian M. Wong Vice President, General Counsel and Corporate Secretary Pacific Gas and Electric Company 300 Lakeside Drive Oakland, CA 94612

Other Administrative Information	The Pacific Gas and Electric Company Health Care Plan for Active Employees Plan is a "welfare" plan.
Funding	The Health Account Plan, the Wellness Program, the Vision Plan, the Dental Plan, the Prescription Drug program, the Mental Health and Substance Use Disorder program, and the Health Account are all "self-insured." This means the Company is responsible for the overall design and administration of the plans and the Company is financially responsible for the payment of the actual costs of the benefit claims. The cost of the benefit claims are paid directly from the Company's general assets, after the claims are incurred. The Employee Assistance Program is insured and is administered by Carelon Behavioral Health. Premiums for this insurance coverage are paid by the Company from its general assets. Manufacturer rebates are earned upon participant purchase of certain prescription drugs. The value of these rebates is based on the contract that Pacific Gas and Electric Company, as Plan sponsor, has with Express Scripts. These rebates are received from Express Scripts approximately six months after the purchase of a drug. Employees pay a portion of the costs, generally through before-tax contributions. The applicable employee contribution is established annually.

Plan Name	Plan Type	Trustee, Insurance Issuer and/or Third-Party Administrator
Anthem Blue Cross Health Account Plan (HAP)	Hospitalization and medical benefits	Third-Party Administrator: Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007
Kaiser Permanente Insurance Company Health Account Plan (HAP)	Hospitalization and medical benefits	Third-Party Administrator: Kaiser Self-Funded Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547 Payor ID # 94320
Dental Plan	Dental benefits	Third-Party Administrator: Delta Dental of California P.O. Box 7736 San Francisco, CA 94120
Employee Assistance Program	Mental health assessment and referral benefits	Insurer: Carelon Behavioral Health P.O. Box 1852 Hicksville, NY 11802-1852
Mental Health and Substance Use Disorder Program	Mental health/substance use disorder hospitalization and medical benefits	Third-Party Administrator: Carelon Behavioral Health P.O. Box 1852 Hicksville, NY 11802-1852
Prescription Drug Program	Prescription drug benefits	Third-Party Administrator: Express Scripts P.O. Box 14711 Lexington, KY 40512

Plan Name	Plan Type	Trustee, Insurance Issuer and/or Third-Party Administrator
Vision Plan	Vision benefits	Third-Party Administrator: Vision Service Plan P.O. Box 997100 Sacramento, CA 95899-7100
Wellness Program	Health and wellness, including tobacco cessation and health screenings	Third-Party Administrator: Quest Diagnostics 10101 Renner Blvd., Lenexa, KS 66219
Health Account	health reimbursement arrangement	Third-Party Administrator: **For the Anthem HAP:** Optum Financial P.O. Box 622317 Orlando, FL 32862-2317 **For the Kaiser HAP:** Kaiser Self-Funded Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547 Payor ID # 94320

The Pacific Gas and Electric Company Health Care Flexible Spending Account Plan

	300 Lakeside Drive
Employer Identification Number	Pacific Gas and Electric Company: 94-0742640
Participating Employers	Pacific Gas and Electric Company PG&E Corporation PG&E Corporation Support Services II, Inc.
Plan Name:	Pacific Gas and Electric Company Health Care Flexible Spending Account Plan
Plan Number:	526
Plan Type	Health Care Expense Reimbursement
Plan Year	1/1–12/31
Plan Administrator	The Employee Benefit Committee (EBC) of PG&E Corporation c/o Pacific Gas and Electric Company Benefits Department 300 Lakeside Drive Oakland, CA 94612

Plan Trustee, Insurance Issuer and/or Third-Party Administrator	Third Party Claims Administrator for the Health Care Flexible Spending Account Plan: If you're an Anthem member or have waived PG&E-sponsored medical coverage, send claims to: Optum Financial P.O. Box 622317 Orlando, FL 32862-2317 If you're a Kaiser member, send claims to: Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 6000 Fargo, ND 58108-6000
Discretionary Authority	The Plan Administrator has the oversight responsibility for the administration of the Plan which includes maintaining records, and making rules, computations, interpretations and decisions that may be necessary for administration of the Plans. The Plan Administrator has the discretionary authority to interpret, construe, and define the terms of the Plan.
Agent for the Service of Legal Process	If you wish to take legal action after exhausting the applicable claims and appeals procedures, a lawsuit may be served on the ERISA Plan Administrator. Service should be directed to: Brian M. Wong Vice President, General Counsel and Corporate Secretary Pacific Gas and Electric Company 300 Lakeside Drive Oakland, CA 94612
Other Administrative Information	The Pacific Gas and Electric Company Health Care Flexible Spending Account Plan is a "welfare" plan.
Funding	The administrative expenses are paid by the Company from general assets and at the Company's discretion by application of forfeited account balances.

The Pacific Gas and Electric Company Long-Term Disability Program

Name and Address of Employer/Plan Sponsor	Pacific Gas and Electric Company Attention: Benefits 300 Lakeside Drive Oakland, CA 94612
Employer Identification Number	Pacific Gas and Electric Company: 94-0742640
Participating Employers	Pacific Gas and Electric Company
Plan Name	Pacific Gas and Electric Company Long-Term Disability Program
Plan Number	503
Plan Type	Income replacement — long-term disability
Plan Year	1/1–12/31

Plan Administrator	The Employee Benefit Committee (EBC) of PG&E Corporation c/o Pacific Gas and Electric Company Integrated Disability Management Department 300 Lakeside Drive Oakland, CA 94612
Plan Trustee, Insurance Issuer or Third-Party Administrator	Third-Party Administrator: Sedgwick Claims Management Services, Inc. P.O. Box 14495 Lexington KY 40512 Plan Trustee: The Bank of New York Mellon One Mellon Center 500 Grant Street, Room 1315 Pittsburgh, PA 15258-0001
Discretionary Authority	The Plan Administrator has oversight responsibility for the administration of the Plan which includes maintaining records, and making rules, computations, interpretations and decisions that may be necessary for administration of the Plan. The Plan Administrator has the discretionary authority to interpret, construe, and define the terms of the Plan.
Agent for the Service of Legal Process	If you wish to take legal action after exhausting the applicable claims and appeals procedures, a lawsuit may be served on the Plan Administrator. Process may also be served on the Plan Trustee (see the row titled "Plan Trustee, Insurance Issuer and/or Third-Party Administrator" in this table for the address). Service should be directed to: Brian M. Wong Vice President, General Counsel and Corporate Secretary Pacific Gas and Electric Company 300 Lakeside Drive Oakland, CA 946125. Process may also be served on the Plan Trustee.
Other Administrative Information	The Pacific Gas and Electric Company Long-Term Disability Plan is a "welfare" plan.
Funding	The Pacific Gas and Electric Company Long-Term Disability Plan is self-insured. Benefits are paid from a trust to which the Company makes contributions.

The Pacific Gas and Electric Company Group Life Insurance Plan

Name and Address of Employer/Plan Sponsor	Pacific Gas and Electric Company Benefits Department 300 Lakeside Drive Oakland, CA 94612
Employer Identification Number	Pacific Gas and Electric Company: 94-0742640
Participating Employers	Pacific Gas and Electric Company PG&E Corporation PG&E Corporation Support Services II, Inc.
Plan Name	Pacific Gas and Electric Company Group Life Insurance Plan
Plan Number	543

Plan Type	Group life and accidental death and dismemberment (AD&D) insurance
Plan Administrator	The Employee Benefit Committee (EBC) of PG&E Corporation c/o Pacific Gas and Electric Company Benefits Department 300 Lakeside Drive Oakland, CA 94612
Plan Trustee, Insurance Issuer and/or Third-Party Administrator	Insurance Issuer: MetLife 425 Market Street, Suite 970 San Francisco, CA 94105-2230
Discretionary Authority	The Plan Administrator has oversight responsibility for the administration of the Plan which includes maintaining records, and making rules, computations, interpretations and decisions that may be necessary for administration of the Plan. The Plan Administrator has the discretionary authority to interpret, construe, and define the terms of the Plan.
Agent for the Service of Legal Process	If you wish to take legal action after exhausting the applicable claims and appeals procedures, a lawsuit may be served on the Plan Administrator. Service should be directed to: Brian M. Wong Vice President, General Counsel and Corporate Secretary Pacific Gas and Electric Company 300 Lakeside Drive Oakland, CA 94612
Other Administrative Information	The Pacific Gas and Electric Company Group Life Insurance Plan is a “welfare” plan.
	The Group life and AD&D benefits are fully insured through MetLife. The basic life and basic AD&D insurance premiums and administrative expenses are paid for by the Company.

The PG&E Corporation Business Travel Insurance Plan

Name and Address of Employer/Plan Sponsor	PG&E Corporation 300 Lakeside Drive Oakland, CA 94612
Employer Identification Number	The Internal Revenue Service has assigned this ID number to the Plan sponsor: PG&E Corporation 94-3234914
Participating Employers	Pacific Gas and Electric Company PG&E Corporation PG&E Corporation Support Services II, Inc.
Plan Name	PG&E Corporation Business Travel Insurance Plan
Plan Number	502
Plan Type	Business Travel Insurance

Plan Administrator	The Employee Benefit Committee (EBC) of PG&E Corporation c/o Pacific Gas and Electric Company Benefits Department 300 Lakeside Drive Oakland, CA 94612
Plan Trustee, Insurance Issuer and/or Third-Party Administrator	Insurance Issuer: ACE American Insurance Company 436 Walnut Street Philadelphia, PA 19106
Discretionary Authority	The Plan Administrator has oversight responsibility for the administration of the Plan which includes maintaining records, and making rules, computations, interpretations and decisions that may be necessary for administration of the Plan. The Plan Administrator has the discretionary authority to interpret, construe, and define the terms of the Plan.
Agent for the Service of Legal Process	If you wish to take legal action after exhausting the applicable claims and appeals procedures, a lawsuit may be served on the Plan Administrator. Service should be directed to: Brian M. Wong Vice President, General Counsel and Corporate Secretary PG&E Corporation 300 Lakeside Drive Oakland, CA 94612
Other Administrative Information	The Business Travel Insurance Plan is a “welfare” plan.
	The business travel insurance benefit is fully insured through ACE American Insurance Company. The premiums are paid by the Company, and all benefits are paid by ACE American Insurance Company.

The Pacific Gas and Electric Company Retirement Plan

Name and Address of Employer/Plan Sponsor	Pacific Gas and Electric Company Benefits Department 300 Lakeside Drive Oakland, CA 94612
Employer Identification Number	Pacific Gas and Electric Company: 94-0742640
Participating Employers	Pacific Gas and Electric Company PG&E Corporation PG&E Corporation Support Services II, Inc.
Plan Name	Pacific Gas and Electric Company Retirement Plan
Plan Number	001
Plan Type	Pension: Defined Benefit
Plan Year	1/1–12/31

Plan Administrator	The Employee Benefit Committee (EBC) of PG&E Corporation c/o Pacific Gas and Electric Company Benefits Department 300 Lakeside Drive Oakland, CA 94612 1-800-700-0057
Plan Trustee, Insurance Issuer and/or Third-Party Administrator	Plan Trustee: The Bank of New York Mellon One Mellon Center 500 Grant Street, room 1315 Pittsburgh, PA 15258-0001 See the row titled "Funding" in this table for more information.
Discretionary Authority	The Plan Administrator has oversight responsibility for the administration of the Plan which includes maintaining records, and making rules, computations, interpretations and decisions that may be necessary for administration of the Plan. The Plan Administrator has the discretionary authority to interpret, construe, and define the terms of the Plan.
Agent for the Service of Legal Process	If you wish to take legal action after exhausting the applicable claims and appeals procedures, a lawsuit may be served on the Plan Administrator. Process may also be served on the Plan Trustee (see the row titled "Plan Trustee, Insurance Issuer and/or Third-Party Administrator" in this table for the address). Service should be directed to: Brian M. Wong Vice President, General Counsel and Corporate Secretary Pacific Gas and Electric Company 300 Lakeside Drive Oakland, CA 94612
Other Administrative Information	There are two types of "pension" plans. A "defined benefit" plan provides a specific benefit using a formula; the amount of your benefit depends among other things, upon your pay and your credited service with the Company. A "defined contribution" plan provides an individual account for each participant; the amount you receive as a benefit depends upon the amount contributed to your account and the investment performance of the contributions. The Pacific Gas and Electric Company Retirement Plan is a defined benefit pension plan.
	The Retirement Plan has been an employer-paid plan since 1973. The amount of each year's Company contribution is determined by the Employee Benefit Committee (EBC) based upon the advice of the Retirement Plan's actuary and in accordance with various laws and regulations which govern contributions to retirement plans. Company contributions are paid to bank trustees for safekeeping. Investment managers are appointed by EBC to direct the investment of the contributions paid to bank trustees. Bank trustees, insurance companies and investment managers are currently employed to invest or act as custodians of Retirement Plan assets.

Collective Bargaining Agreement	The Plan is maintained pursuant to multiple collective bargaining agreements. A copy of the agreements may be obtained by respective members and beneficiaries upon written request to: Pacific Gas and Electric Company Human Resources – Labor Relations 300 Lakeside Drive Oakland, CA 94612

PG&E Corporation Retirement Savings Plan for Union-Represented Employees (formerly called the Pacific Gas and Electric Company Savings Fund Plan for Union-Represented Employees)

Name and Address of Employer/Plan Sponsor	PG&E Corporation Benefits Department 300 Lakeside Drive Oakland, CA 94612
Employer Identification Number	94-3234914
Participating Employers	Any affiliate or subsidiary of PG&E Corporation which participates in the Plan, including: ▪ PG&E Corporation ▪ Pacific Gas and Electric Company
Plan Name	PG&E Corporation Retirement Savings Plan for Union-Represented Employees
Plan Number	002
Plan Type	Defined contribution stock bonus plan with an employee stock-ownership plan component and a cash or deferred arrangement designed to qualify under section 401(k) of the Internal Revenue Code (IRC) and meet ERISA section 404(c).
Plan Year	1/1–12/31
Plan Administrator	The Employee Benefit Committee (EBC) of PG&E Corporation c/o Pacific Gas and Electric Company Benefits Department 300 Lakeside Drive Oakland, CA 94612 1-800-788-2363
Plan Trustee, Insurance Issuer and/or Third-Party Administrator	Plan Trustee: Fidelity Management Trust Company c/o Administrative Team for PG&E Corporation Retirement Savings Plan for Union-Represented Employees Fidelity Investments 245 Summer Street Boston, MA 02210
Discretionary Authority	The Plan Administrator has oversight responsibility for the administration of the Plan which includes maintaining records, and making rules, computations, interpretations and decisions that may be necessary for administration of the Plan. The Plan Administrator has the discretionary authority to interpret, construe, and define the terms of the Plan.

Agent for the Service of Legal Process	If you wish to take legal action after exhausting the applicable claims and appeals procedures, a lawsuit may be served on the Plan Administrator. Process may also be served on the Plan Trustee (see the row titled "Plan Trustee, Insurance Issuer and/or Third-Party Administrator" in this table for the address). Service should be directed to: Brian M. Wong Vice President, General Counsel and Corporate Secretary PG&E Corporation 300 Lakeside Drive Oakland, CA 94612
Other Administrative Information	There are two types of "pension" plans. A "defined benefit" plan provides a specific benefit using a formula; the amount of your benefit depends among other things, upon your pay and your credited service with the Company. A "defined contribution" plan provides an individual account for each participant; the amount you receive as a benefit depends upon the amount contributed to your account and the investment performance of the contributions. The Pacific Gas and Electric Company Retirement Savings Plan for Union-Represented Employees is a defined contribution plan.
Funding	The Retirement Savings Plan for Union-Represented Employees offers eligible employees a tax-advantaged way to save for retirement. The Plan also includes an Employee Stock Ownership Plan. The Plan is intended to qualify under §401(a) and §401(k) of the Internal Revenue Code. The Plan is also intended to satisfy the requirements of §404(c) of the Employee Retirement Income Security Act of 1974. Employees who want to participate in the Plan may contribute a portion of their salary to the Plan on a before-tax basis, a Roth basis, an after-tax basis, or a combination of all three. When an eligible employee elects to make contributions to the Plan, certain participant contributions are eligible for matching employer contributions.
Collective Bargaining Agreement	The Plan is maintained pursuant to multiple collective bargaining agreements. A copy of the agreements may be obtained by respective members and beneficiaries upon written request to: Pacific Gas and Electric Company Human Resources – Labor Relations 300 Lakeside Drive Oakland, CA 94612

Contacts

This section provides addresses, group numbers, phone numbers, and website addresses so you can contact the organizations that manage or administer the benefit plans.

If You Have Questions

If you have any questions about your benefit options, dependent eligibility or any other benefits, you can send a secure email to the PG&E Benefits Service Center by logging onto PG&E's Benefits Portal (accessible through PG&E@Work For Me or mypgebenefits.com), or you can call the PG&E Benefits Service Center at **1-866-271-8144**.

Plan	Group No.	Phone No.	Website	Address
PG&E Self-Funded Plan **Administered by Anthem Blue Cross** *Health Account Plan (HAP)*	PZG170 157	1-800-964-0530 Hours: 7 a.m. – 8 p.m. Pacific time M–F	anthem.com	Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007
PG&E Self-Funded Plan **for Kaiser Members:** *Health Account Plan (HAP), including prescription drug coverage*	**North** Utility: 603702-7 Corporation: 603702-8 **South** Utility: 231142-7 Corporation: 231142-8	North: 1-800-663-1771 South: 1-800-533-1833 Hours: 7 a.m. – 7 p.m. Pacific time M–F 7 a.m. – 5 p.m. Pacific time Saturdays	my.kp.org/ca/pge	Kaiser Self-Funding Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547

Plan			Group No.	Phone No.	Website	Address
Tax-Advantaged Accounts for Anthem and Waived Coverage Members: *Health Account* *Health Care Flexible Spending Account (HCFSA)* *Dependent Care Flexible Spending Account (DCFSA)*	None	1-877-271-8144 Hours: 5 a.m. – 5 p.m. Pacific time M–F	Available through PG&E's Benefits Portal Available through PG&E@Work For Me or by visiting mypgebenefits.com.			Optum Financial Attn: Claims Department P.O. Box 622317 Orlando, FL 32862-2317
Tax-Advantaged Accounts for Kaiser Members: *Health Account* *Health Care Flexible Spending Account (HCFSA)* *Dependent Care Flexible Spending Account (DCFSA)*	None	1-877-750-3399 Hours: 5 a.m. – 7 p.m. Pacific time M–F	kp.org/healthpayment			Kaiser Foundation Health Plan Inc. SF c/o Health Payment Services P.O. Box 1540 Fargo, ND 58107-1540

Plan	Group No.	Phone No.	Website	Address
Prescription Drug Program Administered by Express Scripts *For HAP administered by Anthem Blue Cross*	PGE0000	1-800-718-6590 Hours: 24 hours a day/7 days a week year-round, except Thanksgiving and Christmas Day	express-scripts.com	Express Scripts P.O. Box 14711 Lexington, KY 40512
Mental Health and Substance Use Disorder Program Administered by Carelon Behavioral Health *For HAP administered by Anthem Blue Cross, and HAP administered by Kaiser Permanente Insurance Company*	None	1-888-445-4436 Hours: 24 hours a day/7 days a week	www.carelonbh.com/pge	Carelon Behavioral Health P.O. Box 1852 Hicksville, NY 11802-1852
Dental Plan Administered by Delta Dental	IBEW and SEIU:1515-0101 ESC:1515-0106	1-888-217-5323 Hours: 5 a.m. – 5 p.m. Pacific time M–F	deltadentalins.com/PG&Ehttp://deltadentalins.com/pg&e	Delta Dental of California P.O. Box 997330 Sacramento, CA 95899-7330

Plan	Group No.	Phone No.	Website	Address
Vision Plan Administered by Vision Service Plan	Union: 00401601-Div 0115	1-800-877-7195 Hours: 5 a.m. – 8 p.m. Pacific time M–F 6 a.m. – 5 p.m. Pacific time Saturday	vsp.comhttp://www.vsp.com/	Vision Service Plan Customer Service Department 3333 Quality Drive Rancho Cordova, CA 95670
Retirement Savings Plan — 401(k) Administered by Fidelity	Plan No.: 001 EIN: 94-3234914	1-877-743-4015 Hours: 5:30 a.m. – 9 p.m. Pacific time M–F	401k.com	Fidelity Investments 245 Summer Street Boston, MA 02210
Edelman Financial Engines	Plan No.: 001 EIN: 94-3234914	1-877-743-4015 (ask for Edelman Financial Engines) Hours: 6 a.m. – 6 p.m. Pacific time M–F	401k.com (click the Edelman Financial Engines link)	Edelman Financial Engines Advisors, LLC 1050 Enterprise Way, 3rd Floor Sunnyvale, CA 94089
Retirement Plan — Pension	Plan No.: 001 EIN: 94-0742640	1-800-700-0057 Hours: 7:30 a.m. – 3:30 p.m. Pacific time M–F	myPensionConnect.comhttps://pge.benefitcenter.com/	Secure messaging with a Pension representative

Plan		Group No.	Phone No.	Website	Address
COBRA	None	1-866-271-8144 Hours: 5 a.m. – 5 p.m. Pacific time M–F	Available through PG&E's Benefits Portal ▪ Available through PG&E@Work For Me or by visiting mypgebenefits.com		Optum Financial P.O. Box 2639 Omaha, NE 68103
Wellness Program (Health Screenings) Administered by Quest Diagnostics	None	1-866-271-8144 Hours: 7:30 a.m. – 5 p.m. Pacific time M–F	my.questforhealth.com		10101 Renner Blvd., Lenexa, KS 66219 wellness@questdiagnostics.com
Wellness Program Personify Health	None	1-888-671-9395 M–F 5 a.m. - 6 p.m. Pacific time	app.personifyhealth.com		
Employee Assistance Program Insured and administered by Carelon Behavioral Health	None	1-888-445-4436 Hours: 24 hours a day/ 7 days a week	mypgebenefits.com > Mental Health and Family Support > Employee Assistance Program or carelonwellbeing.com/pge		Carelon Behavioral Health P.O. Box 1852 Hicksville, NY 11802-1852

Plan	Group No.	Phone No.	Website	Address
PG&E Leave Management, Short-Term Disability (Utility employees) and Paid Family Leave	None	1-855-732-8217 Hours: 5 a.m. – 5 p.m. Pacific time M–F Limited after-hours assistance available 24 hours a day/7 days a week	Information about Leaves, Short-Term Disability (STD) and Paid Family Leave (PFL) benefits: mypgebenefits.com > Time Off and Accommodations Claims Management: claimlookup.com/pge	Sedgwick Claims Management Services, Inc. P.O. Box 14495, Lexington, KY 40512
PG&E Long-Term Disability (LTD)		1-855-732-8217 Hours: 5 a.m. – 5 p.m. Pacific time M–F	General Information: mypgebenefits.com > Time Off and Accommodations Claims Management: claimlookup.com/pge	Sedgwick Claims Management Services, Inc. P.O. Box 14495 Lexington, KY 40512
Group Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance Administered by Telus; Insured by MetLife	74300	1-866-271-8144 Hours: 7:30 a.m. –5 p.m. Pacific time M–F Fax: 1-866-545-7517	mypgebenefits.com/	MetLife P.O. Box 14401 Lexington, KY 40512-4401

Plan	Group No.	Phone No.	Website	Address
Travel Assistance and Identity Theft Program Administered by AXA Assistance	74300	1-800-454-3679 (inside US) 312-935-3783 (outside US) Hours: 24 hours a day/ 7 days a week	webcorp.axa-assistance.com/ Username: axa Password: travelassist	
Will Preparation and Estate Resolution Services Administered by Hyatt Legal Plans	74300	1-800-821-6400 Hours: 5 a.m. – 4 p.m. Pacific time M–F	legalplans.com	
Tuition Refund Program Administered by EdAssist	Utility Standard: HR-1101S	1-888-718-2235 5 a.m. - 5 p.m. Pacific time M–F	mypgebenefits.com > select Financial Health > Tuition Refund Program	EdAssist 350 No. Clark Street #500 Chicago, IL 60654 Email: Send a Help Ticket or Application Comment via the TAMS online portal at: tamsonline.org/pgetuition