Your Benefits

Build a better you with PG&E's benefits.

Wondering where to start?

Read this guide and keep it handy for future reference. It highlights what you need to know and do to make the most of your PG&E benefits.

What's inside?

Click on the page numbers to go directly to that page.

Look for the flag.
It means you need to take action.

Where to find legal information about your benefits

These legal documents provide more details about your benefits:

Annual Summary of Benefits and Coverage (SBC)

The annual SBC is an easy-to-understand summary of a health plan, showing how you and the plan would share the cost for covered services.

SBCs allow you to make apples-to-apples comparisons of different health plans, which can make it easier to choose a plan.

Annual Legal Information Booklet

The annual **Legal Information** booklet provides important information about your rights under PG&E's health plan.

This booklet includes legal notices that are required to be distributed annually.

Electronic version:
Go to **mypgebenefits.com > Resources > Legal Notices**.

Paper version:
Call the PG&E Benefits Service Center at **1-866-271-8144** to request a paper copy.

Summary Plan Description (SPD)

The **Summary of Benefits Handbook** (PG&E's SPD) is an important document that explains:

- The provisions of your health, retirement and welfare benefit plans
- How the plans work
- Eligibility rules for coverage
- How benefits are calculated and paid
- How to file a claim and appeal claim denials

Electronic version:
Go to **mypgebenefits.com > Resources > Summary of Benefits Handbooks**.

Paper version:
Call the PG&E Benefits Service Center at **1-866-271-8144** to request a paper copy.

This **Your Benefits** guide is a summary of your benefits. It does not include the important legal definitions or limits that are in plan documents or contracts governing your benefits, and it does not replace those legal documents. In case of conflict, those legal documents govern your benefits. Since future conditions affecting the company cannot be foreseen, the company reserves the right to amend or terminate the plans at any time, subject to notice provisions required under applicable collective bargaining agreements.

You can find additional plan details in the **Summary of Benefits Handbook**, available at **mypgebenefits.com > Resources > Summary of Benefits Handbooks** or by calling the PG&E Benefits Service Center.

Nondiscrimination and accessibility

PG&E's Health Plans do not discriminate on the basis of race, color, national origin, age, disability or sex in their health programs and activities. For people with disabilities, PG&E's Health Plans provide free aids and services, such as qualified sign language interpreters and written information in other formats. If you need these services, contact PG&E's Accommodations Team:

Email: **Accommodations-Req@pge.com**

Phone: **925-459-7270**

For people whose primary language is not English, PG&E's Health Plans provide free language services, such as qualified interpreters and information written in other languages. If you need these services, contact the PG&E Benefits Service Center by phone:

1-866-271-8144 (TTY: 1-800-424-0253)

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-271-8144 (TTY: 1-800-424-0253)**.

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。
請致電 **1-866-271-8144 (TTY: 1-800-424-0253)**。

Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-866-271-8144 (TTY: 1-800-424-0253)**.

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-866-271-8144 (TTY: 1-800-424-0253)**.

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-866-271-8144 (TTY: 1-800-424-0253)** 번으로 전화해 주십시오.

Armenian ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-866-271-8144 (TTY (հեռատիպ)՝ 1-800-424-0253)**:

Farsi **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-271-8144 (TTY: 1-800-424-0253) تماس بگیرید.

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-866-271-8144 (TTY:** телетайп: **1-800-424-0253).**

Japanese 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-866-271-8144 (TTY: 1-800-424-0253) まで、お電話にてご連絡ください。

Arabic ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
اتصل برقم 1-866-271-8144 (رقم هاتف الصم والبكم: 1-800-424-0253).

Punjabi ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।
1-866-271-8144 (TTY: 1-800-424-0253) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយឥតគិតឈ្នួល
ត្រូវ ទូរស័ព្ទ គឺអាចមានសំរាប់បំរើអ្នក។ 1-866-271-8144 (TTY: 1-800-424-0253) ។

Hmong LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-866-271-8144 (TTY: 1-800-424-0253)**.

Hindi ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-866-271-8144 (TTY: 1-800-424-0253) पर कॉल करें।

Thai เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร
1-866-271-8144 (TTY: 1-800-424-0253)

If you think a PG&E Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with PG&E's Plan Administrator, who has been designated to coordinate PG&E Health Plan's compliance with applicable nondiscrimination rules. To contact the Plan Administrator, call: **1-866-271-8144 (TTY: 1-800-424-0253)**

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, PG&E's Plan Administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at **https://www.hhs.gov/sites/default/files/ocr-60-day-frn-cr-crf-complaint-forms-508r-11302022.pdf**.

Health coverage required by California

California state law requires that most California residents have qualifying health insurance. Make sure you're enrolled in a medical plan that meets these requirements. Otherwise, you could be subject to a state tax penalty (see **ftb.ca.gov**). The PG&E-sponsored plans and Medicare meet the state requirements.

NOTICE REGARDING WELLNESS PROGRAM

Effective October 1, 2023

PG&E's health screening program is a voluntary wellness program available to all employees that are eligible for the Health Account Plan (HAP). The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee (an individual's) health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a health screening, which will 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.

Employees who choose to participate in the wellness program will receive incentives paid through a health reimbursement account (Health Account credits of up to an additional $500 for single coverage or $1,000 for family coverage) for completing a health screening and testing tobacco-free or completing Virgin Pulse's free telephonic tobacco cessation program. Although you are not required to participate in the health screening, tobacco-free test, or tobacco cessation program, only employees (individuals) who do so will receive the full incentive amount. If you are unable to participate in any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Quest Diagnostics at **1-866-271-8144**, option 1 then option 3, or at **wellness@questdiagnostics.com**.

The results from your health screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and PG&E may use aggregate information they collect to design a program based on identified health risks in the workplace, Quest Diagnostics will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual who will receive your personally identifiable health information is a health coach in order to provide you with services under the wellness program, unless you authorize other health care providers to view this information.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision in regard to you. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the PG&E Benefits Service Center at **1-866-271-8144**.

New employees

Welcome to PG&E!

At PG&E, our Purpose is delivering for our hometowns, serving our planet and leading with love. We bring this Purpose to life by living our Virtues: being trustworthy, empathetic, curious, tenacious, nimble and owners of the business.

We have taken a stand that everyone and everything is always safe and that it will be enjoyable to work with and for PG&E.

Our benefits reflect our commitment to you. Our benefits encourage your safety and wellbeing—and they reflect the diversity of our employees by offering a wide range of physical, emotional and financial support to help you build a better you.

Explore this guide to learn how to make the most of your PG&E benefits.

Your benefits at a glance

Benefit	When you're eligible
Medical Health Account Plan (HAP) + Health Account	**Immediately** **If you want coverage, you must enroll within 31 days of your hire date** **NOTE:** If you enroll near the end of the 31-day deadline, your first benefit premium deduction could be for two months—the cost of the first month's premium retroactive to your hire date, plus the cost of the second month's premium. You'll be responsible for paying the total premium cost for both months. **Special rules for Hiring Hall employees and retirees who become regular employees** Were you a Hiring Hall employee or retiree eligible for PG&E-sponsored retiree medical coverage—and did you convert to regular employee status? If you enroll for employee coverage, it will start on the **first of the month following your hire date**—even if you waived Hiring Hall or retiree medical coverage.
Dental	
Vision	
Flexible Spending Accounts Health Care Dependent Care	
Health and wellness	**Immediately**
Life and accident insurance	**Management, Administrative & Technical (A&T) and PG&E Corporation employees:** • You're eligible to enroll or change your elected coverage anytime • On your hire date, you automatically get $10,000 of company-paid basic life insurance and either $10,000 or $250,000 of company-paid basic accidental death and dismemberment (AD&D) insurance, depending on your job level **Union-represented employees:** • You're eligible to enroll after you have six months of service and attain regular status • You can enroll or change your elected coverage anytime after you become eligible to enroll • After you attain regular status, you automatically get $10,000 of company-paid basic life insurance and either $10,000 or $250,000 of company-paid basic accidental death and dismemberment (AD&D) insurance, depending on your job level **Elect your beneficiary** See page 122 for details
Commuter Transit Program	**Immediately** • You can enroll or change your elections anytime • The cutoff is the fifth of the month for benefits to be ready the following month

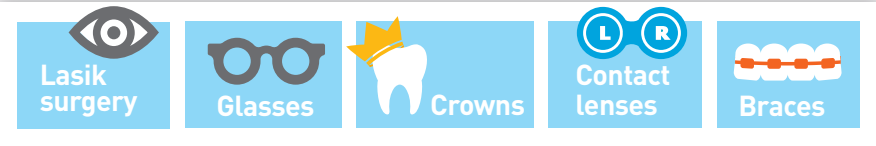
Benefit	When you're eligible
401(k) Retirement Savings Plan	**All employees:** **Immediately:** You can enroll and start making contributions **Anytime:** You can change, stop or re-start your contributions **30 days after you're hired:** If you haven't already enrolled, you'll be automatically enrolled at an 8% contribution level. See pages 144–151 for details about the plan, including when you're eligible for a company match. **Elect your beneficiary** See page 149 for details
Pension PG&E Retirement Plan	**Immediately eligible to participate** You become fully vested in the cash balance pension formula after three years of service or age 55 (employees with the final pay or final average pay pension formula become fully vested in their pension formula after five years of service or age 55) **Elect your pre-retirement beneficiary** See page 153 for details
Retiree medical	**When you retire after age 55 with at least 10 years of service**
Postretirement life insurance	**When you retire after age 55**
Voluntary Plan	**Immediately** Eligible California Pacific Gas and Electric Company (Utility) employees are automatically enrolled in PG&E's Voluntary Disability and Paid Family Leave Plan **You can opt out of the Voluntary Plan within 31 days of your hire date** in order to remain with State Plan coverage retroactive to your hire date (see page 9 for details) PG&E Corporation employees are automatically covered by California's State Disability Insurance and Paid Family Leave Plan.
Time off + other work/ life benefits	**Various rules** See pages 134–142 for details

Benefit details

Earning Health Account credits

You get a Health Account when you enroll in the Anthem or Kaiser Permanente Health Account Plan (HAP).

When you're first hired and every January 1 after that, PG&E credits your Health Account just for being enrolled in the HAP—plus, you can earn extra Health Account credits to spend on eligible health expenses.



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 Virgin Pulse. 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 and the year after you were hired by taking one health screening and by testing tobacco-free or completing the telephonic tobacco cessation program, administered by Virgin Pulse. 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 and the year after you were hired.

See page 27 for Health Account details.

Where to get your health screening

There are four convenient locations where you can get your health screening:

1. At a Quest Diagnostics® Patient Service Center (PSC)
2. At your doctor's office
3. At an onsite event
4. At home using self-collection materials

See page 31 for details about how to get a screening at one of these locations.

Voluntary Disability and Paid Family Leave Benefit Plan (the "Voluntary Plan")

Eligible California Pacific Gas and Electric Company (Utility) employees are automatically enrolled in PG&E's Voluntary Disability and Paid Family Leave Benefit Plan. As a new employee, the coverage is effective immediately.

The Voluntary Plan pays a wage replacement benefit if you're unable to work and experiencing a wage loss due to a non-work-related injury or health condition, including pregnancy, to bond with a new child, care for a family member, or due to a "qualifying military event (exigency)" arising out of the overseas military deployment of your family member.

This plan provides richer benefits and is offered in place of the California State Disability Insurance (SDI) and Paid Family Leave plan (the "State Plan"). The Voluntary Plan's richer benefits include:

- 60%* of your weekly salary replaced—with no weekly cap
- Streamlined application and pay process, including pay through PG&E's payroll cycle
- Available to all eligible employees—regardless of tenure, and at no additional cost (same cost as the State Plan)

If you prefer to remain in the State Plan, you can opt out of the Voluntary Plan through your myPlans Connect account **within 31 days of your hire date**. Your State Plan coverage will be effective retroactive to your hire date.

After your first 31 days, you can opt in or out of the Voluntary Plan anytime during the year, with changes effective according to a special schedule available at **mypgebenefits.com > Time Off and Accommodations > Voluntary Disability and Paid Family Leave Benefit Plan**.

Anyone who opts out of the PG&E Voluntary Plan is required by state law to continue participating in the State Plan, which includes paying State Plan contributions and submitting claims for benefits through the state.

The cost of contributions for the Voluntary Plan is the same as for the State Plan. Actual amounts will show on your pay statement.

Visit **mypgebenefits.com** for details and to see a comparison of State and Voluntary Plan benefits. The comparison will help you understand the richer benefits offered through the Voluntary Plan. To see information about State Plan benefits, visit **edd.ca.gov**.

WARNING: If you're a California Utility employee and you opt out of the Voluntary Plan, you won't receive PG&E-sponsored Supplemental Short-Term Disability or Paid Family Leave wage continuation benefits.

PG&E CORPORATION EMPLOYEES

PG&E Corporation employees in California are automatically covered by the California State Disability Insurance (SDI) and Paid Family Leave plan (the "State Plan"). You don't need to enroll for this coverage.

*55% benefit with no weekly cap (and no supplemental wage continuation benefits) for Hiring Hall, outage, temporary additional, probationary intermittent, interns and summer hire employees. At no time will an employee's weekly benefit amount under the Voluntary Plan be less than what the state would have otherwise provided.

What you need to do

Within 31 days of your hire date

1. Read this guide.

2. Review the benefits you can elect now:

- Health Account Plan (HAP): Medical coverage through Anthem or Kaiser Permanente
- Dental
- Vision
- Health Care Flexible Spending Account (FSA)
- Dependent Care FSA

3. Decide what benefits you want to elect, and enroll online or by phone no later than 31 days after your hire date.

NOTE: If you enroll near the end of the 31-day deadline, your first benefit premium deduction could be for two months—the cost of the first month's premium for coverage retroactive to your hire date, plus the cost of the second month's premium. You'll be responsible for paying the total premium cost for both months.

If you're an eligible California Utility employee, you can opt out of the Voluntary Plan within 31 days of your hire date in order to remain with State Plan coverage effective retroactive to your hire date (see pages 136 and 137 for details).

DON'T BE LATE

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.

Your next chance to enroll will be the next fall during Open Enrollment or when you experience a life event that would allow you to add or drop a dependent—like getting married or divorced. See page 19 for details.

Elect your beneficiaries

You'll need to elect beneficiaries for these benefits:

- Life and accident insurance—see page 122
- 401(k)—see page 149
- Pre-retirement pension beneficiary—see page 153

These are all separate elections. Your beneficiary elections for one benefit won't carry over to another benefit.

How to enroll

You can enroll online or by phone.

Online

Log in to your myPlans Connect account.

Registering is easy:

Using a PG&E computer within the network: Go to ***PG&E@Work for Me*** and click **About Me > My Benefits > myPlans Connect**. You'll be automatically logged in to your account.

OR

From a personal device: Go to **mypgebenefits.com** and click **Learn More** under **Manage Your Benefits**.

1. Click **Get Started** under **New Users**.
2. Follow the prompts to register your account and set up your user ID and password.
3. Confirm your email address and add a mobile phone number as a contact method.
4. Choose your desired contact method to receive a temporary numeric code to confirm your identity each time you log in.

That's all it takes to get 24/7 access to your personalized benefits account. You'll be able to see your benefits; update your dependents; and find tools, resources and details about your benefits.

By phone

Call the PG&E Benefits Service Center:

1-866-271-8144

Monday–Friday, 7:30 a.m.–5 p.m. Pacific time

LOGGING IN SECURELY

myPlans Connect uses multi-factor authentication to keep your information secure. Each time you log in outside of *PG&E@Work for Me*, you'll need your:

- User ID
- Password
- Temporary numeric code that will be sent to your email address or mobile phone number (you'll need to receive a new code each time you log in)

Be sure to use a unique, long password—at least eight characters—to help keep your account secure.

Need help? Call the PG&E Benefits Service Center: **1-866-271-8144**.

Ready to enroll?

Review your options.

Decide what benefits to elect and what family members to cover.

Check your address.

The Kaiser Permanente Health Account Plan (HAP) is only available in some ZIP codes. Make sure your home address is correct.

Review your dependents.

As an employee, you have an opportunity to enroll your eligible dependents in PG&E-sponsored health coverage.

Generally, you can enroll dependents online or by phone. You'll need to provide your dependent's name, birth date and Social Security number. You will be asked to provide other dependent verification documents to the PG&E Benefits Service Center to confirm your dependent's eligibility.

If you or any of your dependents are or will soon be eligible for Medicare (age 65+ or disabled), you must do two things **90 days before becoming eligible for Medicare:**

- Enroll in Medicare Parts A and B.
- Notify the PG&E Benefits Service Center by logging in to myPlans Connect and entering a Life Event or by calling **1-866-271-8144**.

You can't enroll without your Medicare ID.

You can enroll your children up to age 26 for medical coverage. They can be employed or married—and they don't have to be students.

You can cover disabled dependents age 26 or older only if they meet both of these conditions:

- They were already enrolled in a PG&E-sponsored medical plan when they turned 26—and
- They were medically certified as disabled by a PG&E-sponsored medical plan before they turned 26

You may not cover disabled dependents age 26 or older if they fail to meet either one of these conditions.

Check your confirmation statement.

You'll get a paper confirmation statement if:	You'll get an online confirmation statement if:
You don't have an email address on file with the PG&E Benefits Service Center **OR** **You updated your communication preferences and requested paper communications**	**You have an email address on file with the PG&E Benefits Service Center** The PG&E Benefits Service Center will send you an email notifying you when your confirmation statement is ready to print. You'll need to log in to your myPlans Connect account to print your confirmation statement.

Is there an error? Contact the PG&E Benefits Service Center to correct any enrollment errors within 31 days of your hire date.

Your next opportunity to change your coverage will be the next Open Enrollment for benefits effective the following year—or when you have an eligible life event, such as getting married or having a baby. See page 19 for more information about life events.

If you don't enroll

Planning to opt out of PG&E-sponsored health coverage?

You'll have no PG&E-sponsored health coverage. Your next opportunity to enroll will be the next Open Enrollment for benefits effective the following year—or when you have an eligible life event, such as getting married or having a baby. See page 19 for more information about life events.

Health coverage required by California

Make sure you're enrolled in a medical plan that meets California state requirements for qualified health coverage. Otherwise, you could be subject to a state tax penalty. See page 5 for more information.

All employees

At PG&E, our Purpose is delivering for our hometowns, serving our planet and leading with love. We bring this Purpose to life by living our Virtues: being trustworthy, empathetic, curious, tenacious, nimble and owners of the business.

We have taken a stand that everyone and everything is always safe and that it will be enjoyable to work with and for PG&E.

Our benefits reflect our commitment to you. Our benefits encourage your safety and wellbeing—and they reflect the diversity of our employees by offering a wide range of physical, emotional and financial support to help you build a better you.

We also offer job-specific programs designed to support and improve your physical and mental resilience—so you can be at your best on or off the job.

Explore this guide to learn how to make the most of your PG&E benefits.

Benefits you can elect

You can elect or change these benefits once a year during Open Enrollment:

- Health: Medical, dental, vision
- Flexible Spending Account (FSA): Health Care and/or Dependent Care

You can elect or change these benefits anytime:

- Life and accident insurance
- Commuter Transit Program
- For Management and A&T employees in San Francisco, Emeryville, Oakland and Berkeley: Paid Sick Leave Designee
- Eligible PG&E Utility employees are automatically enrolled in the Voluntary Plan for disability and Paid Family Leave, and can opt out or in of the Voluntary Plan anytime during the year through myPlans Connect, with changes effective according to a special schedule (visit **mypgebenefits.com** for details about the Voluntary Plan). PG&E Corporation employees are automatically covered by California's State Disability Insurance (SDI) and Paid Family Leave Plan.

Participation rules for health coverage

Changing coverage if your life changes

Getting married or divorced? Having a baby or adopting?

Big changes like these are **life events**. Chances are, you'll want to change your benefits coverage, too—like adding or dropping a dependent.

EXAMPLE

If you have a domestic partner and you later get married to your domestic partner or to someone else, you must drop domestic partner coverage.

You have 31 days from the date of an eligible life event to make allowable midyear changes to your coverage (180 days from the birth or adoption of a child).

ARE YOU AND YOUR SPOUSE BOTH PG&E EMPLOYEES?

If you and your spouse are both PG&E employees and one is Union-represented and the other is not, you're not allowed to cover each other as a dependent.

To elect coverage, you each must enroll separately as an employee.

Warning! Penalties for ineligible dependents

It's your responsibility to make sure your enrolled dependents are eligible.

You must drop ineligible dependents from coverage within 31 days of the date they become ineligible. If you cover an ineligible dependent, you'll be required to pay back the cost of their health care coverage—up to two full years' worth. In addition, you may be subject to termination of employment.

To drop ineligible dependents, call the PG&E Benefits Service Center or log in to myPlans Connect.

WANT MORE INFORMATION?

For details about eligibility requirements and allowable midyear changes, see the *Summary of Benefits Handbook* at mypgebenefits.com > Resources > Summary of Benefits Handbooks.

Medical

PG&E pays most of the cost of your medical coverage—approximately 93%.

You pay the rest with before-tax contributions from your paycheck. Nationally, employees pay on average 20% to 25% of the cost of their coverage.

Visit **mypgebenefits.com > Resources > Rates** to see monthly medical premiums.

Health Account Plan (HAP) + Health Account

The Health Account Plan (HAP) is available through Anthem or Kaiser Permanente, depending where you live.

The HAP helps build a better you by doing more than protecting you when you're under the weather—it helps you improve your health. You'll have access to:

- Four free primary care visits a year for each enrolled person—that's four per enrolled dependent, not just four per enrolled family
- Some free prescription drugs, some free immunizations and some free preventive services
- Built-in financial incentives for making healthy choices—the PG&E-funded Health Account
- Free, annual health screenings so you can take action to improve or maintain your health numbers
- A no-cost tobacco-free program to help you kick that habit for good
- Virtual appointments with a doctor, counselor or psychiatrist through the telehealth program
- Health and wellness programs with something for just about everyone

Two organizations administer the following health and wellness services for PG&E:

Quest Diagnostics	Virgin Pulse	join.virginpulse.com/pgewellness	Virgin Pulse app
Health screenings Tobacco tests	Health coaching Tobacco cessation	Health check survey Team challenges Journeys	Nutrition guide Sleep guide

Definitions

Use these definitions to help you understand the information on the following pages.

Premiums

The monthly amount charged for health care coverage. You and PG&E share the cost of premiums.

PG&E pays most of the cost of your medical coverage. You pay for your share of premiums with before-tax contributions from your paycheck.

Health Account

A non-taxable account funded by PG&E to use for eligible health expenses. You automatically get the Health Account when you enroll in the Health Account Plan (HAP). See page 26 for details.

Annual deductible

The amount you have to pay every year for covered services before the HAP pays.

You can use the Health Account to help pay the annual deductible.

Coinsurance

Your share of the cost of covered health services after you meet the annual deductible. Coinsurance is usually 10% or 20% of the maximum allowed amount under the HAP.

You can use the Health Account to help pay your coinsurance.

Annual out-of-pocket maximum

The annual out-of-pocket maximum is your financial safety net. It limits how much you're responsible for paying for eligible expenses in a calendar year—whether you use your own funds or your PG&E-paid Health Account credits.

After you reach the annual out-of-pocket maximum, the HAP pays 100% of covered services for the rest of the year. The out-of-pocket maximum includes amounts you pay for deductibles and coinsurance.

You can use the Health Account to help pay expenses that count toward your annual out-of-pocket maximum.

Acronyms

FSA: Flexible Spending Account

HAP: Health Account Plan

How the HAP and Health Account work together

1 Each calendar year:

- You and each enrolled family member get four free primary care visits, with no deductible required (see page 38 for details).
- For services and prescriptions that are subject to the annual deductible, you have to pay 100% of your covered expenses until you meet the annual deductible.
- Then, the HAP will start to pay its share of benefits for covered expenses.

2 You can use the Health Account to pay these costs.

If you earn maximum Health Account credits, you'll have enough to pay the entire HAP **deductible**:

- $1,000 for single coverage
- No more than $2,000 for family coverage

3 Next up? Coinsurance.

After you pay the annual deductible, you pay 10% or 20% of most covered services and the plan pays the rest. That's called coinsurance. But you only have to pay coinsurance up to a point.

There are no copays under the HAP, not even for prescriptions. If your doctor or pharmacy wants to charge a copay, tell them there are no copays under this plan—just coinsurance.

4 You're protected by the out-of-pocket maximum.

Each year, you'll never be responsible for paying more for covered expenses than the out-of-pocket maximum:

- $2,400 for single coverage
- No more than $4,800 for family coverage

Out-of-pocket maximum = deductible + coinsurance

5 And—this is BIG:

You'll never actually have to pay the full out-of-pocket maximum with your own money because the Health Account helps pay for these costs.

Putting it all together: Paying for your HAP expenses

You pay

Annual deductible
- $1,000 for single coverage
- No more than $2,000 for family coverage

Coinsurance
10% or 20% of covered expenses after the deductible

Out-of-pocket maximum
Your annual costs for covered expenses are limited to:
- $2,400 for single coverage
- No more than $4,800 for family coverage

(annual deductible + coinsurance = out-of-pocket maximum)

Remember: The Health Account reimburses some of these costs.

HEALTH ACCOUNT CAN REIMBURSE:

Annual deductible if you earn maximum credits

Some coinsurance if you have enough credits

HAP pays

Free services
First four primary care visits per person + some prescriptions + some preventive screenings + some lab tests

Coinsurance
80% or 90% of covered expenses after deductible

Out-of-pocket maximum
100% of covered expenses for the rest of the year after you meet the out-of-pocket maximum

BOTTOM LINE:

If you earn maximum Health Account credits, the most you'll pay out of pocket for covered expenses in a year is:

$1,400 for single coverage	**No more than $2,800 for family coverage**
$2,400 out-of-pocket maximum	$4,800 out-of-pocket maximum
–$1,000 maximum Health Account credits	–$2,000 maximum Health Account credits

++ LEFTOVER CREDITS: If you have leftover Health Account credits at the end of the year, they'll still be available in next year's account—and they can reduce your bottom line even further.

Track your Health Account balance

Anthem: Log in to your **Optum Financial** account through your myPlans Connect account

Kaiser Permanente: Go to **kp.org/healthexpense**

Health Account details

You get a Health Account when you enroll in the HAP. You can use your Health Account to pay for almost everything except premiums:

- **Deductibles**
- **Coinsurance**
- **Whatever you pay out of pocket for eligible medical, prescription drug, dental, vision, mental health and substance use disorder expenses**

Here's how it works:

When you're first hired and every January 1 after that, PG&E credits your Health Account just for being enrolled in the HAP. You can earn even more credits for healthier choices. The credits have no cash value, earn no interest and aren't taxed.

If you enroll in the HAP	SINGLE COVERAGE	FAMILY COVERAGE
You automatically get:	$500	$1,000
If you take an annual health screening:	$250	$500
If you test tobacco-free or complete the free tobacco cessation program:	$250	$500
Yearly total:	$1,000	$2,000

++ LEFTOVER CREDITS: **Any Health Account credits you don't use will still be available in next year's account, giving you an even bigger balance to spend.***

If you move from single to family coverage midyear, you'll get the family level of credits.

*You keep your unused Health Account credits as long as you're enrolled in a PG&E medical plan (including COBRA coverage). You can even use the Health Account later on—for retiree medical expenses—as long as you're eligible for retiree medical coverage.

Who qualifies for an extra $500 credit?

If your base rate of pay is lower than a certain amount as of January 1, PG&E will automatically give you an extra $500 Health Account credit on January 1 of that year. You don't need to do anything to get this credit.

If you get a raise later in the year, you can keep the extra $500 credit. If you think you should have received the extra credit, call **1-866-271-8144,** option 1 and then option 3.

The qualifying wage may change every year. For details, visit **mypgebenefits.com > Physical Health > Health Account Plan and Health Account**.

How to earn extra Health Account credits*

Are you enrolled in the Health Account Plan (HAP)? You can build a better you—and earn annual Health Account credits—by taking an annual health screening and by testing tobacco-free or completing the tobacco cessation program.

Health screenings, tobacco tests and the tobacco cessation program are only for employees eligible for the HAP. You don't have to be enrolled in the HAP to participate in these programs—but you do have to be enrolled in the HAP to earn extra Health Account credits.

You can earn credits for the current year from October 1 through August 31.

EXAMPLE: You can earn credits for 2024 from October 1, 2023, through August 31, 2024.

Quest Diagnostics

Quest Diagnostics administers the health screenings and tobacco tests.

To set up an appointment from any computer or mobile device, go to **my.questforhealth.com**.

- Sign in or register using the registration key: **PG&E2024**
- Then follow the prompts.

Virgin Pulse

Virgin Pulse app

Virgin Pulse administers the telephonic tobacco cessation program.

Before you can access this program, you'll need to set up an account through the Virgin Pulse app or at **join.virginpulse.com/pgewellness**.

***Reasonable accommodation or alternative standard**

If you are unable to participate in any of the health screenings or tests required to earn Health Account credits, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Quest Diagnostics at **1-866-271-8144**, option 1 and then option 3, or at **wellness@questdiagnostics.com**. For details, see page 5 for PG&E's **Notice Regarding Wellness Program**.

Health screenings for employees eligible for the HAP

The first step to good health is knowing how you're doing.
Screenings can assess your risk of developing serious conditions like heart disease or diabetes even before you feel any symptoms. Early detection can help prevent safety incidents and save your life.

Each year, you can get a free health screening—and after you take your screening, you'll earn extra Health Account credits for the year if you're enrolled in the HAP.

Simply take an annual health screening and you'll earn your extra credits for the year:

$250 if you have single coverage

OR

$500 if you have family coverage

There is no pass or fail for the health screenings.

Your health screening results will be sent to a third-party data warehouse and later reported in the aggregate to help PG&E make improvements to the health and wellness program. PG&E will never see individual results.

The only individual who will receive your personally identifiable health information is a health coach in order to provide you with services under the wellness program, unless you authorize other health care providers to view this information. For details, see page 5 for PG&E's **Notice Regarding Wellness Program**.

Get a personalized report after your screening

MyGuide to Health™ personalized report will be available when the results from your health screening are ready on the Quest website. The report will include:

- Personalized action plan
- Easy-to-understand medical summary to share with your doctor
- Tips for improving or maintaining your overall wellness

You'll be able to view and download your report after you get an email notifying you that your results are ready on the Quest website.

Tobacco-free program for employees eligible for the HAP

Whether or not you use tobacco, the tobacco-free program offers something for you.

Each year, if you're enrolled in the HAP, you can earn extra Health Account credits—**$250 for single coverage or $500 for family coverage**—by participating in the tobacco-free program:

Tobacco tests

Test tobacco-free during an optional annual test at a Quest Diagnostics Patient Service Center (PSC), at your onsite health screening or by using your at-home Self-Collection Kit.

OR

Tobacco cessation program

You can complete Virgin Pulse's free, telephonic tobacco cessation program if you test positive for tobacco or if you opt out of the tobacco test because you currently use tobacco.

To get started, you'll need to register through the Virgin Pulse app or online at **join.virginpulse.com/pgewellness**.

READY TO QUIT TOBACCO—FOR GOOD?

Virgin Pulse offers a phone-based tobacco cessation program that gives you one-on-one support from a certified tobacco cessation specialist. Free nicotine replacement therapy is available if needed.

You don't have to take a health screening to participate in Virgin Pulse's telephonic tobacco cessation program. In fact, you can use the program even if you test tobacco-free.

Only employees eligible for the HAP can participate in this program. If you're enrolled in the HAP, you can earn Health Account credits after you complete four calls with a health coach—$250 for single coverage or $500 for family coverage. You're not limited to four calls; you can continue to use the program as long as you like.

NOTE: It can take three months or more to complete the tobacco cessation program.

Enroll early so you can complete the program by August 31 if you want to earn Health Account credits for the current year.

If you enroll in August, you'll have until December 31 to complete four calls to earn Health Account credits for both the current year and the following year.

Start today: Get one-on-one support and expert guidance to help you quit or reduce tobacco use. To get started, you'll need to register through the Virgin Pulse app or online at **join.virginpulse.com/pgewellness**.

Quit together: It's easier to quit tobacco when your spouse or registered domestic partner quits, too. Family members can get help with tobacco cessation through their health plan.

How to get the annual screening and tobacco test

Annual health screenings and tobacco tests are only for employees eligible for the Health Account Plan (HAP). To schedule your appointment from any computer or mobile device, go to **My.QuestForHealth.com**.

- Sign in or register using the registration key: **PG&E2024**
- Then follow the prompts.

You can choose from four locations:

1

At a Quest Diagnostics® Patient Service Center (PSC)

Quest Diagnostics offers screenings at more than 2,000 PSC locations nationwide. After you log in, enter your ZIP code to find a location near you.

The lab technician will draw your blood (2–3 vials) for the health screening and tobacco test. Fasting is not required for the blood draw.

2

At your doctor's office

You'll need to download a **Physician Results Form** at **My.QuestForHealth.com**. Print the form and take it to your doctor to complete and return to Quest Diagnostics.

3

At an onsite event

You can get a fingerstick health screening at an onsite event. Fasting is not required for the fingerstick screening.

Go to **My.QuestForHealth.com** to register and find an onsite screening near you.

Don't see an onsite event near you? Email **wellness@questdiagnostics.com** or call **1-866-271-8144**, option 1 and then option 3.

4

At home

You can request **self-collection materials** at **My.QuestForHealth.com**.

Follow the directions in your kit and return both Qcards to complete your fingerstick health screening and tobacco test.*

***NOTE:** This will require you to stick yourself with a needle. If you're unable to do this, please schedule your screening at a facility.

WHEN YOUR HEALTH ACCOUNT WILL BE CREDITED

You have until August 31 to complete the annual health screening and to test tobacco-free or complete the tobacco cessation program to earn Health Account credits for the current year.

EXAMPLE: You can earn credits for 2024 from October 1, 2023, through August 31, 2024.

It may take three to six weeks for your extra credits to be reflected in your Health Account.

Leftover credits

If you don't spend all your Health Account credits in a year, they'll still be available in your Health Account as long as you're still enrolled in a PG&E-sponsored medical plan. You also get to keep your unused Health Account credits if you:

- Terminate PG&E employment but enroll in the HAP through COBRA
- Go on Long-Term Disability and are enrolled in a PG&E-sponsored medical plan
- Are eligible for PG&E retiree medical coverage and a Retiree Health Account, even if you don't enroll in a PG&E-sponsored retiree medical plan when you retire

Track your Health Account balance

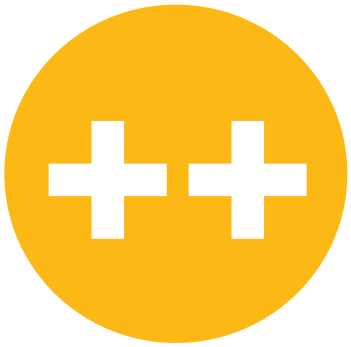
Log in to see your available Health Account balance:

Anthem: Log in to your **Optum Financial** account through your myPlans Connect account

Optum Financial mobile app

Kaiser Permanente: Go to **kp.org/healthexpense**

KP HRA/HSA/FSA Balance Tracker app



Health Account Plan (HAP) details

Your choices: Anthem or Kaiser Permanente?

The big choice for medical coverage is the administrators.

Benefits under both Anthem and Kaiser Permanente are the same, with just a few exceptions (see the benefits overview chart starting on page 39).

Both Anthem and Kaiser Permanente offer mobile apps, making it easy to keep up with your care:

Anthem's Sydney Health app

Anthem members can use the Sydney Health app to:

- Find network doctors and facilities
- View medical claims, access your ID card and get details about your benefits
- Track your spending
- Check your symptoms for free and the app will recommend next steps
- Visit with a doctor (virtual care doctors can assess hundreds of conditions, handle routine care visits, order prescriptions and refills, order labs and schedule follow-ups)
- Ask questions in real time through an interactive chat

Kaiser Permanente app

Kaiser Permanente members can use the Kaiser Permanente app to:

- Choose a doctor by browsing online doctor profiles
- Find facilities and pharmacies near you
- View most lab results
- Refill most prescriptions
- Schedule most appointments
- Pay bills and estimate costs
- Email your care team with nonurgent questions
- Access your digital membership card to check in for appointments and pick up prescriptions

Adult Kaiser Permanente members can download two popular self-care apps at **kp.org/selfcareapps**

Calm **myStrength**

Anthem HAP

Do you like being able to use any doctor you choose? Have a child who is away at school?

The Anthem HAP may be best for you because it has a nationwide network of providers. Outside of the United States, only urgent/emergency care is covered.

You'll pay less when you use in-network Anthem providers and Express Scripts-participating pharmacies because they've agreed to accept Anthem and Express Scripts' negotiated rates.

You may pay a lot more with out-of-network providers—and amounts you pay that are over Anthem's maximum allowed amount won't count toward your annual deductible or out-of-pocket maximum.

Find a doctor

Call the phone number on the back of your Anthem ID card or use the **Sydney Health app** to find network providers.

Kaiser Permanente HAP

Do you live within Kaiser Permanente's service area? Like getting all your care in one place?

The Kaiser Permanente HAP may be best for you. To get benefits, you need to use Kaiser Permanente doctors and facilities—for everything from doctor visits to pharmacies. The only exception is if you have a Kaiser Permanente-qualified medical emergency while you're traveling.

The cost of services will always be within Kaiser Permanente's maximum allowed amount because out-of-network care isn't covered, except for Kaiser Permanente-approved emergency care.

Find a doctor

Call the phone number on the back of your Kaiser Permanente ID card or search for doctors by location at **kp.org** or through the Kaiser Permanente app.

How the HAP works

About the annual deductible

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

$1,000 for single coverage	**No more than $2,000 for family coverage** (maximum $1,000 per person)

Any HAP services that aren't subject to the annual deductible or that are free—like some preventive and primary care—don't apply to your deductible. Most medical, prescription drug and mental health and substance use disorder services do apply to the deductible.

COVER YOUR DEDUCTIBLE

The Health Account is designed to cover your entire medical deductible if you earn maximum extra credits—but it's your choice.

If you earn maximum credits and you use your Health Account just for eligible medical expenses, you'll have enough to pay your entire medical deductible.

How the family deductible works

The family deductible is for family coverage—when you enroll yourself plus one or more family members.

The family deductible is $2,000 at the most, no matter how big your family is—and no more than $1,000 per person. If only one person in the family is accumulating a lot of expenses, the annual deductible is capped at $1,000 for that person—even if the full $2,000 family deductible hasn't yet been met.

This means:

The most one person will have to pay to meet the annual deductible is $1,000—whether that person has single or family coverage.

The most a family will have to pay to meet the annual deductible is $2,000—no matter how big the family is ($1,000 per person—up to $2,000 for the entire family).

Here are two examples.

Family 1	
Ron's expenses:	**$1,000**
Mary's expenses:	**$500**
Total family expenses:	**$1,500**

Family deductible not met but individual deductible met for Ron—so Ron's coinsurance kicks in.

Family 2	
Jim's expenses:	**$500**
Jane's expenses:	**$800**
Johnny's expenses:	**$300**
Jerry's expenses:	**$400**
Total family expenses:	**$2,000**

Family deductible met, so coinsurance kicks in for everyone in the family.

Remember:

You can pay your entire medical deductible—which is a big part of your out-of-pocket maximum—with Health Account credits if:

You earn maximum credits + You don't spend your credits on other expenses like dental and vision.

About the out-of-pocket maximum

The annual out-of-pocket maximum works like a financial safety net by limiting how much you pay for eligible expenses each year.

Your out-of-pocket maximum is the most you'll have to pay for covered services in a calendar year. After you spend this amount on deductibles and coinsurance, the HAP will pay 100% of the cost of covered services for the rest of the year.

The out-of-pocket maximum doesn't include amounts you pay for premiums or penalties; amounts that aren't covered; or amounts that exceed the maximum allowed amounts for out-of-network charges.

TIP

If you've met your annual deductible or out-of-pocket maximum, you may want to get prescription refills or take care of upcoming doctor visits or treatments before January 1, when your deductible and out-of-pocket maximum will reset to zero.

Free primary care

Under the HAP, you and each enrolled family member get four free primary care visits every year. That's four visits per person—not four visits per family.

For example, if you have three people in your family, your family gets 12 free visits; if you have five people, your family gets 20 free visits—four per person. No matter how big your family is, you each get four free primary care visits a year. For additional primary care visits, you pay 10% of the cost with no deductible required.

Primary care doctors and services include:

- General or family practitioners
- Internal medicine doctors
- Pediatricians
- Family nurse practitioners
- OB/GYNs
- Non-hospital urgent care services

Primary care isn't just preventive care. Primary care visits are good for managing chronic conditions like diabetes, hypertension and asthma—as well as for annual physicals, ear aches, sprains and strains, sports injuries, trouble sleeping and much more.

Please note that free doctor visits may include additional tests or services during the visit, which may be covered but won't be free.

Want to know what services are free? Visit **mypgebenefits.com** for details.

PRIMARY CARE IS YOUR KEY TO BETTER HEALTH

Primary care is about choosing a family doctor who knows you and who cares about your "whole person" health—not just your list of conditions. It's about making your primary care doctor your first choice for everything from chronic disease management to school physicals and remedies for that winter cold.

Find a primary care provider

Call the phone number on the back of your Anthem or Kaiser Permanente ID card.

Anthem's Sydney Health app : Find network primary care providers.
Kaiser Permanente app or online at **kp.org:** Search for primary care providers by location.

Benefits overview: HAP benefits for Anthem and Kaiser Permanente

General

Annual deductible
- $1,000 per person
- No more than $2,000 per family

Annual out-of-pocket maximum
- $2,400 per person
- No more than $4,800 per family

Remember:
Out-of-pocket maximum = deductible + coinsurance

If you earn maximum Health Account credits, they can pay for your entire medical deductible—which is a big part of your annual out-of-pocket maximum.

The annual out-of-pocket maximum includes amounts you pay toward the annual deductible—whether you pay with Health Account credits or with your money. It does not include any penalty charges, amounts in excess of the maximum allowed amounts for out-of-network charges, or charges for services that aren't covered.

No lifetime benefit maximum except for infertility services

No pre-existing condition exclusions

Medical	
Primary Care Includes routine physical exams	**Doctor visits** • No deductible • Four free visits a year per enrolled person; you're responsible for 10% of covered charges for additional visits **Note: If one of the first four visits is a physical exam, it counts toward your four free visits.**
Specialty Care	• Deductible required • You're responsible for 20% of covered charges
Preventive Services and Immunizations For a list of free services, go to **mypgebenefits.com > Physical Health > Medical - HAP Anthem** or **Medical - HAP Kaiser**	• No deductible • Free if included on the list of free services and coded as preventive **EXAMPLES: Prostate exams, mammograms and colonoscopies** **Note: Diagnostic tests and ancillary services like anesthesia and facility fees are covered separately and aren't free (see page 42 for Lab Tests and X-Rays, and for Outpatient Hospital).**

continued on next page

DIAGNOSTIC SCREENINGS AREN'T FREE

Your medical plan administrator will determine which screenings are preventive (free) and which screenings are diagnostic (not free).

Preventive screenings—such as mammograms and colonoscopies—are free, unless they're coded as diagnostic.

For example, if your doctor sees something in a preventive mammogram and orders followup mammograms, those followup 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.

Remember—you can use the Health Account to help pay for these expenses.

Medical	
Maternity Care	**Office visits** • No deductible • Free **Screenings and tests (e.g., sonograms)** • Deductible required • You're responsible for 20% of covered charges **Hospital-based delivery** • Deductible required • You're responsible for 20% of covered charges **Anthem members:** Authorization required for delivery stays beyond 48 hours for vaginal delivery (96 hours for Cesarean section)
Well-Baby Care	• No deductible • Free to age two
Infertility Services	• Deductible required • You're responsible for 20% of covered charges • $7,000 lifetime benefit maximum; includes balances from prior plans
Urgent Care	Covered as **primary care**—no deductible; you're responsible for 10% of covered charges after the first four free primary care visits

continued on next page

Avoid emergency room rates for primary and urgent care

Some hospitals advertise themselves as primary and urgent care centers when in fact, they're hospital-based. They charge higher, outpatient hospital or emergency room rates for primary and urgent care. This can make a big difference in how much you pay out of your own pocket.

Always check to see if the facility you want to use is really an urgent care center.

Anthem members:

- Go to **anthem.com/ca/pge**.
- Enter **urgent care** and the **ZIP code** where you want to go.
- Anthem will find the nearest urgent care center for you.
- You can also find urgent care centers using the **Anthem Blue Cross smartphone app**.

Kaiser Permanente members:

- Urgent care is only available where there are medical centers with specific hours.
- Call Kaiser Permanente Member Services and ask them for the nearest urgent care center and hours.
- If you go to a Kaiser Permanente medical office located within a Kaiser Permanente hospital, it's likely to be billed as an emergency, not as urgent care.

LAB AND X-RAY COVERED SEPARATELY

Most lab tests and X-rays aren't free.

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.

Remember—you can use the Health Account to help pay for these expenses.

Medical

Emergency Room	• Deductible required • You're responsible for 20% of covered charges
Ambulance Services	• Deductible required • You're responsible for 20% of covered charges
Lab Tests and X-Rays For a list of free services, go to **mypgebenefits.com > Physical Health > Medical - HAP Anthem** or **Medical - HAP Kaiser**	**Routine preventive screenings that are on the list of free services** • No deductible • Free **All other procedures, including diagnostic tests and most lab tests** • Deductible required • You're responsible for 20% of covered charges • Anthem requires preauthorization for certain X-rays (call Anthem Member Services at the number on your ID card to find out if a procedure needs to be preauthorized)
Chiropractic and Acupuncture	• Deductible required • You're responsible for 10% of covered charges for first five visits per year; 20% for additional visits **Kaiser Permanente members:** You can self-refer to an American Specialty Health (ASH) provider **Anthem members:** Preauthorization required after five visits per year
Outpatient Physical Therapy, Speech Therapy, Occupational Therapy	• Deductible required • You're responsible for 10% of covered charges for first five visits per year; 20% for additional visits **Anthem members:** Preauthorization required after 24 visits per year
Outpatient Hospital	• Deductible required • You're responsible for 20% of covered charges

continued on next page

Medical	
Hospital Stay	• Deductible required • You're responsible for 20% of covered charges **Anthem members:** Preauthorization required for non-emergency care, $300 penalty if not obtained; covers semi-private room (private if medically necessary)
Skilled Nursing Facility	• Deductible required • You're responsible for 20% of covered charges **Anthem members:** Preauthorization required, $300 penalty if not obtained **Anthem and Kaiser Permanente members:** Excludes custodial care
Home Health Care	• Deductible required • You're responsible for 20% of covered charges **Anthem members:** Preauthorization required, $300 penalty if not obtained **Anthem and Kaiser Permanente members:** Excludes custodial care
Hospice Care	• No deductible • Free **Anthem members:** Preauthorization required, $300 penalty if not obtained **Anthem and Kaiser Permanente members:** Excludes custodial care
Durable Medical Equipment	• Deductible required • You're responsible for 20% of covered charges **Anthem members:** Preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained
Hearing Aids	• Deductible required • You're responsible for 20% of covered charges for evaluation, fittings, equipment • Limited to one medically necessary hearing aid per ear every three years

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Anthem HAP: Preauthorization required through Anthem's AIM Specialty Health program

Preauthorization by your health care provider is required 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.

Before you receive treatment for certain procedures, call Anthem Member Services at the phone number on your ID card to find out if a procedure needs to be preauthorized.

Mental Health and Substance Use Disorder Care

Administered by Carelon Behavioral Health and Kaiser Permanente (see details below)

Outpatient Mental Health	• No deductible • You pay 10% of covered charges **Anthem HAP:** Carelon Behavioral Health provides this care **Kaiser Permanente HAP:** Kaiser Permanente provides this care
Inpatient Mental Health	• Deductible required • You pay 20% of covered charges **Anthem HAP:** Carelon Behavioral Health provides this care. Requires preauthorization by Carelon Behavioral Health; $300 penalty if you fail to notify Carelon Behavioral Health within 48 hours; no limit on number of stays **Kaiser Permanente HAP:** Kaiser Permanente provides this care
Outpatient Substance Use Disorder Care	• No deductible • You pay 10% of covered charges **Anthem HAP:** Carelon Behavioral Health provides this care **Kaiser Permanente HAP:** Kaiser Permanente provides this care
Inpatient Substance Use Disorder Care	• Deductible required • You pay 20% of covered charges **Anthem HAP:** Carelon Behavioral Health provides this care. Requires preauthorization by Carelon Behavioral Health; $300 penalty if you fail to notify Carelon Behavioral Health within 48 hours; no limit on number of stays **Kaiser Permanente HAP:** May use Carelon Behavioral Health or Kaiser Permanente. All substance use treatment requires preauthorization. When using a Carelon Behavioral Health provider, a $300 penalty applies if you fail to notify Carelon Behavioral Health within 48 hours of admission to a facility. No limit on number of stays.
Applied Behavioral Analysis (Autism Treatment)	• No deductible • Free • No limits through Carelon Behavioral Health **Anthem HAP:** Carelon Behavioral Health provides this care **Kaiser Permanente HAP:** You may use Carelon Behavioral Health or Kaiser Permanente **Preauthorization required with Carelon Behavioral Health**

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TIP

Need guidance from someone who has successfully dealt with his or her own substance use disorder or that of a loved one?

Contact a Peer Volunteer (see page 68).

PREFER A TELEHEALTH VISIT?

The Kaiser Permanente HAP offers telehealth for mental health when clinically appropriate. Visit **kp.org/mentalhealth** for more information.

The Anthem HAP offers telehealth mental health support through Carelon Behavioral Health's Talkspace program and LiveHealth Online. See pages 48 and 49 for details.

Prescription Drugs	
List of Free Prescription Drugs For a list of free services, go to **mypgebenefits.com > Physical Health > Medical - HAP Anthem** or **Medical - HAP Kaiser**	Select drugs are free, no deductible **Anthem members:** In order for the drug to be free, you must use the Express Scripts mail-order program **Kaiser Permanente members:** You must use either a Kaiser Permanente pharmacy or Kaiser Permanente's mail-order program for medications on the list of free prescription drugs
Retail Drugs	• Deductible required (combined with medical deductible) • You're responsible for 15% of covered charges for generic; 25% for brand (**Anthem members:** Generic Incentive Provision and Step Therapy Provision apply) • 30-day supply **Anthem members—mandatory mail order for most maintenance drugs:** You can get the first three fills of the same maintenance drug at a retail pharmacy; no coverage for additional fills except through the Express Scripts mail-order program **Kaiser Permanente members:** No mandatory mail order; you can use a Kaiser Permanente pharmacy or Kaiser Permanente mail order for maintenance drugs

continued on next page

How were medications selected for the list of free prescription drugs?

Pharmacists and outside consultants did extensive studies to identify the drugs that are most often needed for chronic conditions and that are sometimes not taken by the people who should be taking them.

The idea is that by offering these prescription drugs free of charge, people who *should* take them *will* take them—for example, people with hypertension or high cholesterol. By making these prescription drugs free of charge, we're making it easier for people with these common conditions to improve their health. The list was never meant to include all conditions, all medications or all dosage variations.

Prescription Drugs	
Mail-Order Drugs	**For drugs not on the list of free medications** • Deductible required • You're responsible for 10% of covered charges for generic; 20% for brand (**Anthem members:** Generic Incentive Provision and Step Therapy Provision apply) **Anthem members:** 90-day supply **Kaiser Permanente members:** 100-day supply
For Anthem Members Only: 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. Any generic/brand price differential you pay is a non-covered expense and therefore does not count toward your annual deductible or out-of-pocket maximum.
For Anthem Members Only: Step Therapy Provision	For certain medications, the HAP requires that members try generic medication or lower-cost brand-name alternatives first, instead of higher-cost brand-name drugs. Members who require higher-cost brand-name drugs for medically necessary reasons can appeal to Express Scripts by having their doctor submit the reason why the higher-cost brand-name drug is required. Express Scripts will review and approve exceptions if the higher-cost brand-name drugs are required.
Drugs for Infertility and Sexual Dysfunction	• Deductible required • Standard retail and mail-order coverage applies

ONE DEDUCTIBLE AND ONE OUT-OF-POCKET MAXIMUM

Under the HAP, there are no separate deductibles or out-of-pocket maximums for prescription drug benefits or for mental health and substance use disorder services.

Instead, there's only one overall annual deductible and one overall out-of-pocket maximum for all HAP benefits.

Remember—you can use the Health Account to help pay for your deductible.

Extra medical resources when you need extra care

PG&E supports the health, wellness and safety of our employees—a core value for PG&E.

To help you get the right care right away, PG&E offers a variety of medical resources—whether for personal health issues or work-related discomfort or injuries.

Telehealth for Anthem and Kaiser Permanente HAP

Do you need to consult with a health care provider—but don't have time to go to their office? Get medical advice, treatment plans, mental health support and prescriptions through convenient telehealth visits.

Anthem members: Telehealth through the HAP

If your Anthem network provider offers telehealth visits through their practice, these visits will count toward your four free visits under the HAP. Coinsurance for primary care or specialty telehealth visits is the same as for in-person visits.

Ask your Anthem network provider if they offer telehealth visits. This is a different benefit from Anthem's LiveHealth Online telehealth program. See page 49 for details about LiveHealth Online.

TALKSPACE MENTAL HEALTH SUPPORT FOR ANTHEM MEMBERS

Anthem members can access mental health support through Carelon Behavioral Health's Talkspace program.

Anthem members ages 13 and older can get matched with a therapist, psychologist, psychiatrist or facility provider via telehealth.

Register by going to **talkspace.com/carelonbehavioralhealth** and entering the primary subscriber's eight-digit PG&E personnel number (PERNR) when the Talkspace website prompts for the member/subscriber ID.

Kaiser Permanente members: Free Video Visits

Kaiser Permanente's free Video Visits program lets you connect with a Kaiser Permanente doctor through your computer or mobile device anywhere, anytime. Connecting from work? You'll need to use your cell service—not PG&E's Wi-Fi.

To get started, go to **kp.org/mydoctor/videovisits**. You'll need to log in to your Kaiser Permanente account to register for the free service. Ask your doctor about scheduling a Video Visit.

Anthem LiveHealth Online: Available for everyone

Anthem's LiveHealth Online telehealth program gives you convenient access to a board-certified doctor, psychiatrist or licensed therapist through your computer or mobile device.

You and your dependents do not have to be enrolled in the HAP to use LiveHealth Online.

Anthem members: You pay 10% coinsurance for LiveHealth Online primary care visits, no deductible required; 20% coinsurance after the deductible for LiveHealth Online specialty care visits.

All others: You pay the full cost for LiveHealth Online visits.

You can use your Health Account to pay for these visits.

LiveHealth Online: Get the care you need

Medical

Talk to a doctor in English or Spanish about any common medical condition:

- Fever
- Urinary tract infections
- Eczema, rashes, skin lesions
- Cough and colds
- Sore throat
- Flu
- Sinusitis
- Heartburn

Medical for kids

Visit with a doctor who's willing to treat children under age 18 through video visits.

Psychology

Talk with a therapist or psychologist for help with:

- Stress
- Life transitions
- Relationship issues
- Trouble dealing with an illness
- Anxiety
- Depression
- Grief
- Panic attacks

Psychology for kids

Children ages 10 through 17 can have online therapy visits. The parent or guardian must add the child to their account and help the child sign in and start the visit.

Allergy

Talk to a doctor who knows about the latest trends and treatments for allergy care and receive:

- Coupons for allergy relief products
- Educational guide
- Access to an allergy app, which can help you keep track of the pollen counts in your area

Psychiatry

If you're 18 or older, you can talk with a board-certified psychiatrist for help with:

- Stress
- Bipolar Disorder
- Post-Traumatic Stress Disorder (PTSD)
- Medication management
- Obsessive Compulsive Disorder (OCD)
- Anxiety
- Depression
- Grief
- Panic attacks

Sleep Specialist Visits

Visit with a board-certified sleep specialist for a wide range of sleep disorders. You'll get:

- An initial evaluation
- Referral for testing if appropriate
- A personalized treatment plan
- Follow-up visits as needed

Get started with LiveHealth Online

Register at **livehealthonline.com** or download the free iPhone or Android **LiveHealth Online app**.

Home

Connect through your computer or mobile device.

Work

Connect through your cell service—not through PG&E's Wi-Fi.

Want more information about LiveHealth Online?

Email **customersupport@livehealthonline.com** or call **1-888-548-3432**.

Anthem Blue Distinction Centers for Specialty Care®

Are you an Anthem member? You have access to the Blue Distinction Specialty Care program for the following serious health problems:

Bariatric surgery
Cardiac care
Complex and rare cancers
Knee and hip replacement
Spine surgery
Solid organ and bone marrow transplants

Anthem's Blue Distinction Specialty Care program helps you find Anthem network hospitals that are recognized for excellent care, with faster recovery times and lower costs. Blue Distinction Centers have met strict standards created by expert doctors and health care groups—standards that include:

- Better treatment results
- Fewer complications
- Fewer re-admissions than other hospitals

It's easy to find Blue Distinction Centers:

Log in for personalized search
Find doctors, hospitals and more in your plan's network.

Use Member ID for basic search
Find doctors, hospitals and more near you. You can also search your medical plan without logging in.

Select a plan for basic search
Find out if a doctor, hospital or other care provider is in-network for the plan you select.

1. Once you're in, you can select from the following drop downs:
   A. What type of care are you searching for? **Medical**.
   B. What state do you want to search with? **California** (or the state in which you are searching).
   C. What type of plan do you want to search with? **Medical (Employer-Sponsored)**.
   D. Select a plan/network **Blue Cross PPO (Prudent Buyer)—Large Group**.
2. Enter the location you are searching (city, county or ZIP).
3. Under **Search by Care Provider**, pick **Hospital**.
4. Under the heading of filters:
   A. Click on **More Filters** to see the Blue Distinction dropdown option. Select **Blue Distinction** dropdown.
   B. Select **type of specialty care needed** from Blue Distinction dropdown options.
   C. Click on **both Blue Distinction Center + and Blue Distinction boxes** to get all available centers. You'll see Blue Distinction Center listed.
   D. To see Blue Distinction details, click on **View Details** on right side of listed facility, then **Recognitions**.

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**.

Kaiser Permanente coordinated cancer care

If you're a Kaiser Permanente member, your cancer care will be coordinated for you. Kaiser Permanente 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 Permanente'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 Permanente's cancer resources, contact your doctor.

Want to learn more?

For details, visit the Anthem and Kaiser Permanente member pages at **mypgebenefits.com** **> Physical Health > Medical - HAP Anthem** or **Medical - HAP Kaiser**.

KnovaSolutions: Personalized help managing health concerns

For all active employees—and family members, too, if they're enrolled in the Anthem or Kaiser Permanente Health Account Plan (HAP)

KnovaSolutions is a confidential, voluntary and free personal health service provided by an independent team, which includes a registered nurse, pharmacist, medical research librarian, certified diabetic care and education specialist and registered dietitian.

The KnovaSolutions team can help you better understand and manage medical care, treatments and medications, so you can make the best health decisions possible. You will be in control of your health decisions, with your clinical team supporting you. KnovaSolutions services are designed to enhance, not replace, your patient-provider relationship.

If you or a family member is identified as someone that may benefit from KnovaSolutions, you'll get an introductory letter followed by a phone call. You can also contact KnovaSolutions to see if you qualify for services.

Have questions? Want to contact a nurse today?

Email: **ContactKnovaSolutions@workpartners.com**

Call: **1-800-355-0885**

Representatives are available Monday–Friday 5 a.m.–5 p.m. Pacific time, or evenings by appointment.

For details, visit **mypgebenefits.com** > **Physical Health** > **KnovaSolutions**.

24/7 Nurse Care Line: For work-related health concerns

For all employees—if you're injured on the job or experiencing work-related discomfort

The 24/7 Nurse Care Line, administered by WorkCare, provides **immediate access** to a nurse or doctor for work-related discomfort or injury—so you don't have to travel or spend hours in a waiting room.

Even if you don't immediately feel pain, it's important to report and treat all work-related discomfort and injuries as early as possible so they don't worsen over time.

If you experience a work-related discomfort or injury, call **1-888-449-7787** or report via the NCL app and notify your supervisor. If your injury is severe and warrants immediate medical attention, call 911.

For details, visit **mypgebenefits.com** > **Physical Health** > **24/7 Nurse Care Line**.

PG&E Health Centers and the Premise Health Wellness Center: Holistic health services

For all active HAP-eligible employees

The PG&E Health Centers and the Premise Health Wellness Center were specially designed for PG&E employees. Services from Premise Health deliver high-quality, convenient, affordable care, with the focus on primary and preventive care.

All medical teams take a holistic approach—learning about your medical history and lifestyle to provide shared decision-making in the care and treatment options that make sense for you.

The Fresno and San Carlos onsite health centers are staffed with nurse practitioners, and the medical team at the Oakland near-site wellness center includes a physician, nurses, medical assistants, a health risk care management nurse/wellness coach, a physical therapist, chiropractor and acupuncturist.

Key services include:

- Coordinated and customized primary and preventive care services
- Same-day acute and urgent care services
- Secure electronic medical records
- Virtual Video Visits
- Health screenings and InBody body composition assessments
- Clinical lab services
- Health education and coaching
- Care management
- Occupational health/work injury care
- Chiropractic and acupuncture treatments (Oakland only)
- Physical therapy (in person Oakland only; virtual video available from all clinics)

If you're enrolled in the Anthem HAP: The clinics will bill Anthem just like other clinics do. If there's an outstanding balance, **you'll be responsible for promptly paying it**. You can file a claim for reimbursement from your Health Account or Health Care Flexible Spending Account (FSA), if you have one.

If you're enrolled in the Kaiser Permanente HAP: You'll have to pay the full cost at the time of service. You can file a claim for reimbursement from your Health Account or Health Care FSA, if you have one.

TIP

You can use your Kaiser Permanente health payment card to pay. You'll have to verify your expenses by submitting an Explanation of Benefits (EOB) or itemized receipt to Kaiser Permanente.

Health education coaching, care management and some other services are provided at no cost to you regardless of your insurance plan.

You can make appointments, complete clinic forms and secure-message your provider after creating an account at the clinic's Patient Portal: **mypremisehealth.com**.

For details about the PG&E Health Centers and the Premise Health Wellness Center—including costs—go to **mypgebenefits.com > Physical Health > Health Centers**.

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Contact information

Patient portal: **mypremisehealth.com**

All hours are Pacific time.

Oakland: Premise Health Wellness Center

2201 Broadway Blvd., Suite 101
Oakland, CA 94612 (two blocks from Lakeside Headquarters)

Clinic hours: 7:30 a.m.–4:30 p.m. (closed for lunch 12:30–1:30 p.m.)

Lab hours: 8 a.m.–12:30 p.m.

510-473-8700

San Carlos: PG&E Health Center

275 Industrial Way, Room 103-104
San Carlos, CA 94070

Clinic hours: 7 a.m.–4 p.m. (closed for lunch 12–1 p.m.)

Lab hours: 8 a.m.–12 noon

650-598-7227

Fresno: PG&E Health Center

3580 E. California Avenue, Bldg B
Room 01-1502
Fresno, CA 93702

Clinic hours: 7 a.m.–4 p.m. (closed for lunch 12–1 p.m.)

Lab hours: 8 a.m.–12 noon

559-263-7555

Health and wellness

Build a better you with PG&E's health and wellness programs. These programs are available to all HAP-eligible employees.

Health and wellness programs offer something for everyone

PG&E has teamed up with two wellness organizations to bring these easy-to-access services to employees eligible for the Health Account Plan (HAP):

Quest Diagnostics®	Virgin Pulse	
Health screenings Tobacco tests	Virgin Pulse portal Health coaching Tobacco cessation program Team challenges	Nutrition Guide Sleep Guide RethinkCare mindfulness and yoga programs

Virgin Pulse: Before you can access any of the Virgin Pulse programs and activities, you must first register.

Mobile: Download the free Virgin Pulse app in the App Store or on Google Play. On the Virgin Pulse app, search and select **PG&E**.

Desktop: Go to **join.virginpulse.com/pgewellness**.

In addition, PG&E offers a variety of other health and wellness services, including:

Industrial Athlete Program	Fitness and gym discounts
Office ergonomics	Wellness Champions
Confidential support for a variety of life challenges through the Employee Assistance Program (EAP)	Confidential help with alcohol and substance use disorder issues through the Peer Volunteer Program

Health coaching and tobacco cessation

Virgin Pulse administers the health coaching and tobacco cessation programs.

The Virgin Pulse portal, telephonic tobacco cessation program and health coaching are available only to employees eligible for the Health Account Plan (HAP).

To access these services, you'll first need to register with Virgin Pulse. On the Virgin Pulse app, search and select **PG&E** or go to **join.virginpulse.com/pgewellness**.

Telephonic coaching through Virgin Pulse

Virgin Pulse health coaches help promote and facilitate growth, healing and wellbeing by using coaching principles and healing modalities that integrate the body, mind, emotion, spirit and environment. The result? Improved health and wellbeing.

You can start by setting goals based on your health risks, needs and interests. After your first call, your coach will schedule regular follow-up calls to see how you're doing, answer your questions and offer suggestions on how to get past any obstacles.

Journeys® Digital Coaching

Would you like to get a better night's sleep? Exercise more? Better manage stress?

Use the Journeys® online coaching tool to make simple, everyday changes to your health, one step at a time. Get a boost of motivation, read evidence-based tips—and start experiencing real results.

Telephonic tobacco cessation program

Want to quit tobacco for good? Would you be happy just cutting back?

You don't have to take a health screening to participate in Virgin Pulse's convenient, phone-based tobacco cessation program. In fact, you can use the program even if you test tobacco-free.

When you sign up for the phone-based tobacco cessation program, you'll be teamed up with a health coach who is also a certified tobacco cessation specialist.

Your tobacco cessation coach will give you one-on-one support and expert guidance to help you quit or reduce tobacco use. Free nicotine replacement therapy is available, if needed.

See page 30 for information about the free tobacco cessation program and how to earn extra Health Account credits if you're enrolled in the Health Account Plan (HAP).

Ready to schedule an appointment? First, register with Virgin Pulse. On the Virgin Pulse app, search and select **PG&E** or go to **join.virginpulse.com/pgewellness**.

Then, contact a health coach or tobacco cessation specialist directly to schedule your first appointment: **1-866-271-8144**, option 1 and then option 4.

Telephonic health coaching and telephonic tobacco cessation appointments are available Pacific time:

- Monday–Thursday: 5 a.m.–8 p.m.
- Friday 5 a.m.–4 p.m.
- Saturday 6 a.m.–noon

Virgin Pulse portal

Looking for health information? Want an easy way to track your nutrition and fitness progress?

The Virgin Pulse portal is designed to help you improve your wellbeing by making small, everyday changes that are focused on the areas you want to improve the most. With daily engagement, you'll build healthy habits, have fun with coworkers and experience the lifelong rewards of better health and wellbeing.

The Virgin Pulse portal is available only to employees eligible for the Health Account Plan (HAP).

Team challenges

Build a better you through healthy competition.

Join your colleagues to compete in the health and wellness challenges offered throughout the year. You can invite your family or friends to join you in a challenge, too.

Want to learn more?

Mobile: Download the free Virgin Pulse app in the App Store or on Google Play. On the Virgin Pulse app, search and select **PG&E**.

Desktop: Go to **join.virginpulse.com/pgewellness**.

Phone: Call **1-866-271-8144**, option 1 and then option 4.

GET STARTED

To access the Virgin Pulse tools and programs, you must first register. On the Virgin Pulse app, search and select PG&E or go to join.virginpulse.com/pgewellness

Mobile:

Download the free Virgin Pulse app in the App Store or on Google Play. On the Virgin Pulse app, search and select **PG&E**.

You'll be able to access all of the portal's tools and features from your smartphone.

Desktop:

- Verify your eligibility, then click **Continue**.
- Then, fill out the online registration form to set up your username and password.

Logging in securely

The Virgin Pulse portal uses multi-factor authentication to keep your information secure. When you log in with your username and password, a message will open on your screen requesting a one-time security code.

A temporary security code will be sent by SMS (text) or email—whichever you prefer. Enter the code into the field provided and you'll be securely logged in.

Be sure your mobile phone number is up to date in your member profile.

Musculoskeletal Disorders (MSD) Strains and Sprains Prevention Program

All employees have access to office and field ergonomics programs that are designed to assess your work tasks, job demands, physical layout, equipment and environmental factors that may contribute to musculoskeletal disorders.

Industrial Athlete Program

If you're an employee in PG&E's physical workforce, you have access to a sports medicine professional who is an Industrial Athlete Specialist (IAS) and who is available for every division. These professionals routinely visit many work locations. If your location isn't part of their normal circuit, you can request a service by calling **1-877-729-1246**.

Industrial Athlete Program services include:

- One-on-one assessments for discomfort (think of having your own athletic trainer at work)
- One-on-one preventive services (stretching, exercise routines, strength, nutrition)
- Group training and "health topic of the month" sessions, where you can learn how to prevent injuries and improve health
- Job observation with an IAS to get help with body mechanics, posture, rest-work cycles and recovery times

You can schedule an in-person appointment at your worksite to get help proactively or at the first sign of musculoskeletal discomfort.

Visit the Industrial Athlete website to learn more about the program and to find contact information for your local industrial athlete specialist: **pge.sharepoint.com/sites/IndustrialAthleteErgo**.

Email **industrialathlete@pge.com** to schedule a tailboard for your team or submit a group services request: **https://forms.office.com/r/cr0ZYJ6Wvnp**.

Office Ergonomics: Preventing injuries at work

Are you an office worker? Follow these guidelines to make sure you're working safely:

- Complete the annual self-assessment and training launched from your RSIGuard dashboard. Log in to **MyLearning** and launch **SAFE-0409** to get Academy credit for the training after you complete it.
- Make a habit of taking regular breaks throughout your day, including any RSIGuard prompted stretch breaks. Regular movement is critical to preventing musculoskeletal disorders.
- Take advantage of self-help resources to work safely on your computer from any location.
- Request a work station evaluation from your RSIGuard dashboard when you:
  - Begin your employment with PG&E
  - Change work tasks or software applications if significantly different, or start a new position
  - Feel the slightest discomfort

To learn more about the resources available to you, visit the Office Ergonomics website at **pge.sharepoint.com/sites/OfficeErgo** or email **officeergonomics@pge.com**.

NOTE: You'll need network access to view the SharePoint pages for Industrial Athlete and Office Ergonomics.

Hinge Health digital clinic for joint and muscle care

PG&E is partnering with Hinge Health to offer wellness care for your joints and muscles.

With Hinge Health, you can do physical therapy remotely. You'll have a customized care plan, a clinical team of experts and ongoing educational resources to help support you on your wellness journey.

Hinge Health is available to you and your eligible dependents at no cost and provides all the tools you need to get moving again from the comfort of your home, including:

- **Instant feedback to guide stretches**
  The Hinge Health app helps you get your form right by providing feedback during your exercise sessions.
- **Personalized exercise therapy**
  You'll be guided through 10 minutes of exercise three times a week, and the level of difficulty will increase when you're ready.
- **Dedicated one-on-one support**
  Your physical therapist and health coach will be there to guide you via text, email or phone call to help tailor the program to you.
- **Women's Pelvic Health Program**
  Hinge Health offers programs for pregnancy, postpartum and menopause to improve bladder control, build core muscles and more.

Visit hinge.health/pge-oe to learn more.

Questions? Call Hinge Health at 1-855-902-2777 or email hello@hingehealth.com.

Fitness and gym discounts

Are you and your family enrolled in the Health Account Plan (HAP)?

You and your enrolled family members are eligible for discounts at many fitness clubs—as well as discounts on select home fitness equipment.

For details, visit **mypgebenefits.com > Physical Health > Wellness Programs** or call **1-866-271-8144** for more information.

Wellness Champions

PG&E's Wellness Champions are employees who have a passion for wellness.

These volunteers help create a healthy culture at PG&E by being "go-to" resources for all things wellness at PG&E, directing employees to PG&E's diverse wellness initiatives.

Interested? You'll have the opportunity to:

- Learn, share and connect with other Wellness Champions at PG&E
- Receive monthly PG&E health and wellness newsletters with wellness tips and learning opportunities
- Encourage fellow PG&Eers to participate in wellness programs
- Create excitement around leading a healthy lifestyle

Visit **mypgebenefits.com > Physical Health > Wellness Programs** to learn more about PG&E's Wellness Champion network.

Lactation Rooms

PG&E offers a supportive environment to enable lactating coworkers and visitors to express milk, breastfeed or chestfeed during work hours.

In many locations, PG&E offers sanitary, lockable Lactation Rooms at Work, where you can safely and privately express milk. For locations, visit **mypgebenefits.com > Mental Health and Family Support > Lactation Rooms**.

Questions or concerns? Email **wellness@pge.com**.

Employee Assistance Program

Wellness isn't just about physical health; it's also about mental and emotional well-being.

The Employee Assistance Program (EAP) offers no-cost, one-on-one, confidential support for a wide variety of life events and concerns via video, phone, text, chat or in person. You and each of your dependents and household members are eligible for up to eight free sessions per issue per year to talk with a licensed EAP counselor about:

- Stress management
- Alcohol and drug issues
- Anxiety or depression
- Family and relationship challenges, and more

EXAMPLE:

You access EAP counseling because you recently moved and are having difficulty adjusting to the change. You'll receive up to eight free counseling sessions to address this concern.

Later in the year, you experience the loss of a loved one and are grieving the loss. Those are two separate issues, so you would receive up to another eight free sessions to address the grief over your loss.

In this example, you would receive up to 16 free counseling sessions to address your issues.

In addition, the EAP offers you financial, legal, and work/life resources:

- Help finding household or pet services
- Referrals to family-care resources (day care, elder care)
- No-cost consultation with a certified financial advisor for tips on paying off your debt or other financial challenges
- No-cost legal consultations on divorce, domestic violence, custody and other legal issues—and reduced fees if you retain the attorney's services

EAP support through Talkspace

Employees and dependents ages 13+ can access EAP benefits through Carelon Behavioral Health's Talkspace program.

Talkspace offers convenient, online therapy through text, audio and video sessions. Visit **pge.mybeaconwellbeing.com** to get started.

Get in touch

- **Visit mypgebenefits.com** to explore all the ways the EAP can help and to find a list of EAP onsite counselors, available onsite and virtually to employees; virtually to dependents.
- **Visit pge.mybeaconwellbeing.com** to schedule an EAP appointment with a counselor in your community via video, phone, text, chat or in person.
- **Call 1-888-445-4436** to get help accessing any EAP services or to speak to a licensed EAP counselor, available 24 hours a day, 7 days a week.
- **Visit achievesolutions.net/pge** for online emotional health resources and more.

Find the right counselor

It's helpful to find a counselor who is trained to treat your problem; who makes you feel comfortable; and who is someone you can trust. Visit **mypgebenefits.com > Mental Health and Family Support > Employee Assistance Program (EAP)** for tips on finding the right counselor.

If you exhaust your no-cost EAP sessions or you'd like to see a counselor who is not in the EAP network, you can see a mental health care provider through the HAP. You'll pay 10% of covered charges, and there's no deductible. See page 44 for details.

Learn to Live

Learn to Live is a digital platform offered through the Employee Assistance Program (EAP). It's built on the principles of cognitive behavioral therapy (CBT) to help you with:

- Social anxiety
- Depression
- Insomnia
- Substance use
- Stress, anxiety and worry

To get started, visit **learntolive.com/welcome/PGE** and register using the code **PGE**. Then take a quick assessment to get matched with the program that's right for you.

After you register, we recommend you sign up for a coach who can monitor your progress and support you throughout the program. You can connect with your Master's-level clinical coach via text, email or phone. You can also add family and friends as teammates for additional encouragement and social support.

Learn to Live is offered at **no cost to you and your dependents ages 13 and up.** It's completely confidential and available anytime, anywhere you have an Internet connection. It's available in both English and Spanish.

Peer Volunteer Program

Get help with alcohol and substance use disorders.

Are you or a family member struggling with alcohol or substance use disorders? You're not alone.

Employees with alcohol or substance use issues are more likely to be involved in workplace accidents—putting their PG&E coworkers and the community at risk. Safety is a core value at PG&E, which is why PG&E offers the free Peer Volunteer Program.

You and your family members can get information about treatment for alcohol and substance use disorders from fellow PG&E employees who are in long-term recovery for their own alcohol/substance use disorder, or that of a loved one. The free program is available in all PG&E service areas.

How it works

For you and your family. You or any dependent can call a Peer Volunteer for help. Alcohol and substance use disorders affect all members of the family—not just the person with the disorder.

Completely confidential. You can ask for help anonymously over the phone. Peer Volunteers will not share your information with anyone else without your permission—including other Peer Volunteers.

People who've walked in your shoes. All Peer Volunteers are PG&E employees who have at least two years of recovery for their own substance use disorder or that of a loved one. Many Peer Volunteers have been in recovery for more than 10 years. All have personally experienced the judgment, shame and guilt that comes with a drinking or drug problem—and they're here to help. Peer Volunteers have been trained by EAP representatives, and they have access to licensed mental health professionals, if needed.

Get in touch

Call any Peer Volunteer listed at mypgebenefits.com > Mental Health and Family Support > Peer Volunteer Program (PVP). Peer Volunteers are available 24/7.

Can't reach a Peer Volunteer? Call the EAP hotline at **1-888-445-4436**, and ask to have a Peer Volunteer call you back.

Interested in becoming a Peer Volunteer, or just want more information? Email **PVP@pge.com** or visit **mypgebenefits.com > Mental Health and Family Support > Peer Volunteer Program (PVP)** to request a brochure or to schedule a 10-minute presentation with a Peer Volunteer.

Dental

Administered by Delta Dental

PG&E pays most of the cost of dental coverage for Management and A&T employees, and all of the cost of dental coverage for Union-represented, full-time employees.

Visit **mypgebenefits.com** **> Resources > Rates** to see monthly dental premiums.

You can use any dentist you choose, but you'll save the most money by using a Delta Dental PPO Network dentist.

Want to estimate your dental costs and see the current status of your calendar-year deductibles and maximums? Use the Cost Estimator Tool at **deltadentalins.com/pg&e** or through the Delta Dental Mobile app.

Remember, you can use your Health Account to pay for coinsurance and other dental charges.

Dental Plan Provisions	
Choice of Dentist	Any; for maximum benefits, use a PPO or Premier Dentist Go to **deltadentalins.com/pg&e** for a list of PPO and Premier dentists
Calendar-Year Deductible	Required for all covered services except diagnostic care, preventive care and orthodontics. You pay only one deductible depending on the type of provider you use. **Delta Dental PPO Network** • $25 per person; no more than $75 per family • Applies if you use only PPO dentists **Delta Dental Premier Network or Non-Participating Dentist** • $50 per person; no more than $150 per family • Applies if you use a Premier Network or Non-Participating dentist—even if you only use them once and you use PPO dentists every other time
Diagnostic and Preventive Care Includes Toothpic virtual screenings	No deductible You're responsible for 15% of covered charges for preventive care: • Two exams per year • Two cleanings per year • Fluoride treatments • Space maintainers • Full-mouth X-rays and Panorex films once every five years • Bitewing X-rays twice a year for dependents up to age 18; once a year for adults ages 18 and older

Basic Care	Deductible required
	You're responsible for 15% of covered charges for basic care:
	• Fillings
	• Root canals
	• Treatment of the gums (periodontia)
	• Oral surgery
	• Extractions
	• Sealants for eligible dependents under age 16
	  ◦ Permanent first molars through age eight
	  ◦ Second molars through age 15

Major Care	Deductible required You're responsible for 15% of covered charges for major care: • Crowns • Onlays • Cast restorations • Inlays • Implants • Bridges
Calendar-Year Maximum Benefit	$2,500 per person (excludes orthodontia)
Orthodontia	50% up to a lifetime maximum benefit of $2,000 per person

Note: All benefits are subject to Delta Dental's maximum allowed amount.

Toothpic teledentistry app

If you're enrolled in the Dental Plan, you can use Delta Dental's photo-based teledentistry app, Toothpic, to receive diagnostic dental screenings from the comfort of your own home.

A Toothpic screening counts as a diagnostic exam under the plan. Register for an account: **deltadental.toothpic.com**.

Vision

Administered by Vision Service Plan (VSP)

PG&E pays the full cost of vision coverage for Management and A&T employees and their families, and the full cost of vision coverage for Union-represented, full-time employees and their families.

Visit **mypgebenefits.com** **> Resources > Rates** to see how much PG&E pays for monthly vision premiums.

Under the VSP Choice Plan, you can use any licensed vision provider you choose, but you'll pay less when you use a VSP provider. If you use a non-VSP provider, you have to pay your bill in full, and VSP will reimburse you based on a schedule of benefits.

Remember, you can use your Health Account to pay for copayments and other vision charges.

Vision Benefits	
Choice of Doctor	Any; for maximum benefits, use a VSP doctor Go to **vsp.com** for a list of VSP providers
Copayments with VSP Doctor	• $10 per exam • Extra $20 per exam for medical and urgent eye care needs through VSP's Essential Medical Eye Care program • $25 for materials (lenses and/or frames)*
Benefits with VSP Doctor All Costco, Walmart and Sam's Club locations are in the VSP network, but not all doctors at those locations accept VSP coverage. Check with your store to find out if VSP optometrists are available.	• **Vision exams**—every 12 months • **Eyeglass lenses**—every 12 months • **Frames**—covered up to $150 once every 24 months (the frame allowance at Costco is $80 every 24 months) • **Standard progressive lenses**—covered in full every 12 months • **Ultraviolet lenses**—covered • **Light-reactive lenses**—covered • **Elective contact lens fitting and evaluation** covered in full every 12 months after a maximum $55 copayment; 15% discount applies to contact lens evaluation and fitting; $150 allowance toward contact lenses every 12 months (you'll be eligible for frames 12 months after you get contact lenses). • **Visually necessary contact lenses**—covered in full in lieu of glasses when obtained from a participating doctor and only with prior authorization from VSP for medically necessary conditions • **Lasik**—covered up to $250 per eye (lifetime limit)
Non-Covered Lens Options	Extra savings on additional glasses and sunglasses, including lens options, from a VSP doctor within 12 months of your last exam

*You're responsible for charges that exceed the plan's maximum allowed amounts—and for the cost of cosmetic extras not covered by the plan, like blended, tinted or oversized lenses.

Special discounts

Frames

You can get an extra $20 to spend on featured frame brands from your VSP doctor.
Go to **vsp.com/specialoffers** for details and a complete list of featured brands.

Retinal screenings

You pay no more than a $39 copayment on routine retinal screenings as an enhancement to your VSP exam.

Essential Medical Eye Care program

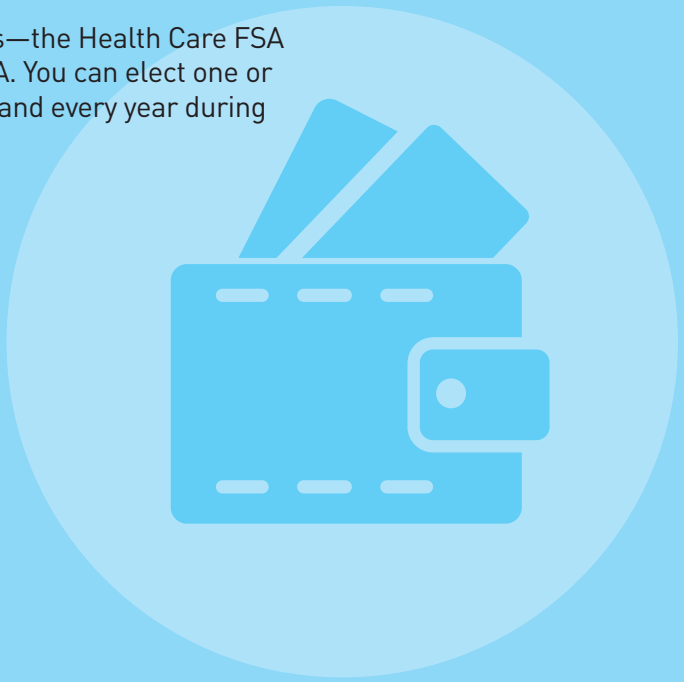
For an extra $20 copay, you can get treatment for medical and urgent eye care services, including pink eye, sudden vision loss, eye trauma and medical follow-up exams

This program also includes screenings for glaucoma, and/or age-related macular degeneration (AMD)—plus retinal screenings for eligible members with diabetes.

Flexible Spending Accounts

A Flexible Spending Account (FSA) lets you set aside a portion of your before-tax earnings to pay for qualified expenses—reducing your taxable income and saving you money.

There are two different FSAs—the Health Care FSA and the Dependent Care FSA. You can elect one or both when you're first hired and every year during Open Enrollment.



Flexible Spending Accounts (FSAs)

You fund the Flexible Spending Accounts (FSAs) with your own money. Your contributions are deducted from your pay before taxes are calculated—reducing your taxable income and saving you money.

Health Care FSA

This account is for eligible health care expenses—medical, dental, vision, mental health and substance use disorder expenses the IRS considers eligible for reimbursement.

You can use the account for yourself—and for your dependents' health care expenses—even if they're not enrolled in your plan.

You can't use this account for dependent day care expenses.
It's only for eligible health care expenses.

Dependent Care FSA

This account is for eligible dependent care services for your dependent family members so you can work.

The IRS allows you to use the account for child and elder care while you work—such as day care or adult care, babysitters, at-home caregivers, preschool, before- or after-school programs and summer day camp.

The IRS generally limits use of the account for children under age 13—but you can also use the account for older children and adults who are physically or mentally incapable of self-care.

You can't use this account for your dependents' health care expenses.
It's only for dependent care services that allow you to work.

Find lists of eligible health care and dependent care expenses at **mypgebenefits.com** > **Financial Health > Spending Accounts**.

Getting started with the FSAs

1. **Each year during Open Enrollment, you must enroll** in the Flexible Spending Accounts (FSAs) if you want to participate and make new contributions for the following year.

2. **The Health Care and Dependent Care FSAs are completely separate accounts.** You can sign up for either or both, but you can't transfer funds from one account to the other.

3. **Your FSA administrator depends on your medical coverage:**
   - **If you're enrolled in the Anthem HAP—**Optum Financial administers your FSA.
   - **If you're enrolled in the Kaiser Permanente HAP—** Kaiser Permanente administers your FSA.
   - **If you waive medical coverage but you elect an FSA—** Optum Financial administers your FSA.

DEADLINE FOR FILING FSA CLAIMS

Current-year expenses:

You have until June 30 of the following year to file claims for expenses incurred through December 31 of the current year.

Health Care Flexible Spending Account (FSA)

Each year, you can set aside a portion of your before-tax pay to help cover the cost of eligible health expenses.

You can be reimbursed even before you have money in your Health Care FSA to cover your claim, up to the annual amount you elected to contribute.

EXAMPLE

You elect to contribute $1,200 for the year. You incur $1,000 in expenses in February—but you've only contributed $200 to your account so far. You can be reimbursed for the full $1,000 right away.

Health Care FSA rules

Contribution limit	Each year, you may contribute up to **$3,050** of your before-tax pay to the Health Care FSA. The IRS may increase this limit for inflation. To check PG&E's current limit, go to **mypgebenefits.com > Financial Health > Spending Accounts**.
Carryovers	You can carry over unused balances up to **$610** to the next year as long as you're eligible to participate in the Health Care FSA as of January 1 of the next year. The IRS may increase this amount for inflation.
Enrollment	You don't have to be enrolled in the Health Care FSA to use carryover balances from the prior year. You do have to be enrolled to make new contributions for the current year.
Claims deadline	You have until **June 30** to file claims for prior-year expenses.
Forfeitures	You forfeit unused amounts over **$610** at the end of the plan year. EXAMPLE: If you have an unused balance of $611, you can carry over $610 and you'll forfeit $1.
Family status changes	You'll be able to make midyear changes to your Health Care FSA election only if you experience a **qualifying life event** such as getting married.

Why participate?

Will you have high out-of-pocket expenses? Do you purchase glasses or contacts every year? Will you need to pay for braces? Do you need extra money to pay for your health expenses—or for your dependents' health expenses?

You may be able to save on taxes by contributing to the Health Care FSA. You use your own money—but it's before-tax money, so you could pay less in taxes.

Estimate carefully. You can only carry over up to $610 in your Health Care FSA. You forfeit the rest if you don't use it.

Need help estimating?

Log in to your myPlans Connect account to use the **Estimate Medical Plan Costs** tool.

Dependent Care Flexible Spending Account (FSA)

Do you have children or elderly parents that need day care so you can work?

The Dependent Care FSA lets you set aside before-tax pay to reimburse eligible dependent care expenses so you can work.

The IRS generally limits use of the account for children under age 13—but you can also use the account for older children and adults who are physically or mentally incapable of self-care.

EXAMPLE: Summer camp

For children under age 13	For children age 13 or older
✔ OK	⊘ Not allowed unless the child is physically or mentally incapable of self-care

This account is not for dependent health care expenses.

How the Dependent Care FSA works

You use your own money to pay expenses and then file claims for reimbursement. There are no debit cards for the Dependent Care FSA.

You can be reimbursed only when you have enough money in your Dependent Care FSA to cover your claim.

You forfeit unused amounts at the end of the plan year. You can't carry over unused amounts.

How much you can contribute

The Internal Revenue Code determines how much you can contribute to the Dependent Care FSA based on your tax filing status and other factors:

$5,000 a year if you're:	$2,500 a year if you're:
• Married filing jointly—**OR** • Single—**OR** • Filing a return as head of household	Married filing separately

Married?
As a couple, you have a combined $5,000 limit—even if you each have access to a separate Dependent Care FSA.

Your annual contributions can't exceed your own or your spouse's income.

Dependent Care FSA rules

Age limit	You may use the account only for children **under age 13**. You may use the account for older children and adults only if they are physically or mentally incapable of self-care.
Grace period	You have until **March 15** of the following year to incur eligible dependent care expenses against contributions made in the current year. EXAMPLE: You contribute to the 2024 Dependent Care FSA. You have until March 15, 2025, to incur eligible dependent care expenses against your 2024 contributions.
Enrollment	You don't have to be enrolled in the current-year Dependent Care FSA to use up prior-year contributions by incurring eligible expenses through the grace period, March 15. You do have to be enrolled to make new contributions for the current year.
Claims deadline	You have until **June 30** to file claims for eligible dependent expenses incurred through the grace period, March 15.
Forfeitures	You'll forfeit **100%** of your unused contributions after the grace period, so be careful to contribute only what you'll need.
Family status changes	You'll be able to make midyear changes to your Dependent Care FSA election only if you experience a **qualifying life event**, such as adopting a young child.

How to get reimbursed for health expenses

There are two accounts that can help you pay for your health expenses:

Health Care Flexible Spending Account (FSA)	Health Account
You elect to participate You don't have to be enrolled in the Health Account Plan (HAP) to elect the Health Care FSA. If you want to participate in the Health Care FSA, you have to elect it during Open Enrollment or within 31 days of your hire date. If you don't elect it, you won't have it.	**You automatically participate** You automatically get the PG&E-funded Health Account when you're enrolled in the Health Account Plan (HAP). Each year, you can earn extra Health Account credits when you complete an annual health screening and test tobacco-free or complete the tobacco-free program. See page 26 for details.
You pay You fund the FSA with contributions deducted from your pay before taxes are calculated, saving you money. PG&E pays nothing.	**PG&E pays** PG&E funds the Health Account for you. You pay nothing.
Forfeit part of your unused balance You forfeit unused amounts over $610 at the end of the plan year. You can carry over a maximum of $610 as long as you're eligible to participate in the Health Care FSA as of January 1 of the next year.	**Keep your unused balance** You generally keep unused Health Account credits. They roll over for future use as long as you stay enrolled in a PG&E-sponsored medical plan.
Dependents don't have to be enrolled You can use the Health Care FSA to help pay for your family's eligible health expenses—even if they're not enrolled as dependents in your Health Account Plan (HAP).	**Dependents must be enrolled** You can use the Health Account to help pay for your family's eligible health expenses— only if they're enrolled as dependents in your Health Account Plan (HAP).

WHICH ACCOUNT PAYS FIRST?

Do you have the Health Account and the Health Care FSA?

Your Health Care FSA is automatically debited first—before your Health Account—to help you avoid forfeiting unused amounts in your FSA.

What expenses are eligible?

You can use the Health Account and the Health Care Flexible Spending Account (FSA) to pay for almost all your health expenses except premiums.

Deductibles, coinsurance and whatever you pay out of pocket for eligible medical, prescription, dental, vision and mental health and substance use disorder expenses are eligible for reimbursement. To see the full list of qualified expenses, including over-the-counter purchases, visit **irs.gov** and look for **Publication 502**.

Here are a few examples:

Medical expenses

- Extra doctor visits beyond your four free preventive visits per year
- Lab tests and X-rays
- Chiropractic and acupuncture visits
- Hospital stays
- Durable medical equipment

Prescription expenses

- Retail drugs
- Mail-order drugs that aren't on the free mail-order drug list

Download the Anthem and Kaiser Permanente free drug lists at mypgebenefits.com > **Physical Health > Medical - HAP Anthem > OR Medical - HAP Kaiser**.

Dental expenses

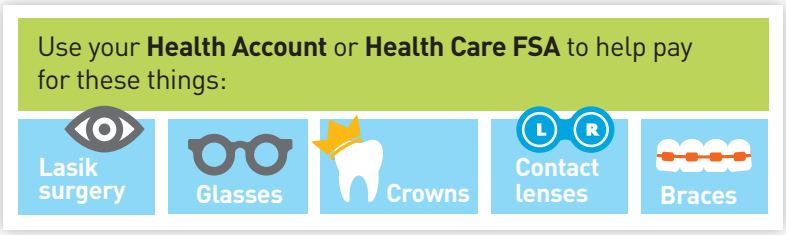
- Office visits
- Fillings
- Oral surgery
- Crowns
- Braces

Vision expenses

- Office visits
- Glasses
- Contact lenses
- Lasik surgery

Mental health and substance use disorder expenses

- Outpatient visits
- Inpatient treatment



Save your EOB

An EOB is an Explanation of Benefits from the claims administrator.

After you visit your doctor, dentist or other health care provider, the claims administrator will mail an EOB to you—a statement that shows how much your health plan paid for your treatment or service—and how much, if anything, you'll owe.

Your Health Account or Health Care Flexible Spending Account (FSA) administrator—Optum Financial or Kaiser Permanente—needs these five pieces of information from your EOB or detailed receipt to verify your expenses are eligible:

- Date of service
- Amount of service
- Provider's name
- Patient's name
- Service provided

Watch out! If your Health Account or Health Care FSA administrator can't verify that your expenses were eligible, the amount of the unverified expense may be added to your taxable income in the following tax year unless you reimburse your account.

DOWNLOAD YOUR EOB

Don't want to wait for your EOB to arrive in the mail? Log in to your claims administrator's website—Anthem, Kaiser Permanente, Delta Dental, VSP, Express Scripts, Carelon Behavioral Health—and download your EOB.

Your EOB is not a bill. Don't pay anything until you first get your EOB and then a bill from your provider.

Anthem members...

...and Health Care FSA participants who waive medical coverage

You can use the Optum Financial payment card if you elect the Anthem HAP or if you waive medical coverage and elect the Health Care FSA.

The card works just like a debit card, drawing from your Health Account and Health Care FSA to pay for eligible expenses.

You can pay with your card when you check in for a visit, when you get a bill or when you shop for eligible over-the-counter items at the store.

Here's how the Optum Financial payment card works:

✓ **Health Account credits**	Your card will be loaded with your annual Health Account credits. Any leftover balances from the current year will be available at the start of the new year.
✓ **Health Care FSA contributions**	**If you elect the Health Care FSA**, your card will be loaded with your annual FSA contribution and any applicable carryover amounts.
✓ **Medical expenses**	You can use the card at the time of service—but it's best to ask your doctor to process your claim first and then bill you after your claim has been processed.
✓ **Prescriptions**	Use the card at Express Scripts-participating pharmacies or with the mail-order program.
✓ **Dental and vision expenses**	You can use the card at the time of service—but it's best to ask your dentist or eye doctor to process your claim first and then bill you after your claim has been processed.
✓ **Over-the-counter purchases**	You can use the card for eligible over-the-counter items such as bandages and contact lens solution. For a list of eligible over-the-counter items, visit **irs.gov** and look for **Publication 502**.

USING THE CARD FOR OVER-THE-COUNTER PURCHASES

See page 87 for tips on how to use your card for over-the-counter purchases.

Optum Financial reimbursement rules

There are three things you need to know about getting reimbursed through Optum Financial:

1 Claims filing deadline

2 When you can use the Optum Financial payment card

3 Deadline for verifying expenses if you use the card

Getting reimbursed	Health Care Flexible Spending Account (FSA)	Health Account
1 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
2 Can you use your card?	**Yes** for current-year expenses **No** for prior-year expenses	**Yes** for current-year expenses **Yes** for prior-year expenses
3 If Optum Financial requests more information—what's the latest you can verify your expense?	You have 180 days to verify your expenses. After 180 days, if you haven't verified your expenses and they total more than $150, **Optum will suspend your card**.	

DON'T USE THE CARD FOR PRIOR-YEAR EXPENSES

Do you have the Health Care FSA and the Health Account?
Claims are always paid from the Health Care FSA first—before your Health Account—to help you avoid forfeiting unused amounts in your FSA.

When you use the card to pay for prior-year expenses, the card automatically debits your FSA. The card can't distinguish between current-year and prior-year FSA contributions—and it's against IRS rules to use the current-year FSA to pay for prior-year expenses.**You'll have to repay the claim with your own money.**

The solution: Use **Pay Provider** or **Reimburse Myself** for prior-year expenses. See page 88 for details.

DO YOU ONLY HAVE A HEALTH ACCOUNT?

You can use the Optum Financial health payment card to pay for prior-year expenses.

Be careful. If you have both the FSA and the Health Account, it's best to use Pay Provider or Reimburse Myself for prior-year expenses.

Using your card for over-the-counter purchases

Many retailers—especially big-box retailers with pharmacies—can automatically verify many eligible health expenses, so you won't have to submit itemized receipts.

TIP: Pay at the pharmacy register.

Try to use the pharmacy register when you're shopping—especially when you're at a big-box retailer that has a pharmacy.

Pharmacy registers are typically set up to recognize eligible items and will accept the card. Front registers might reject the card.

EXAMPLE:

You're shopping at a big-box store and you're buying bandages, contact lens solution and toilet paper.

If you're paying at a register that recognizes eligible items, the card will work for the bandages and contact lens solution, but it will reject the toilet paper, so you'll have to pay for that with your own money.

You won't have to submit a claim for the bandages and contact lens solution because the card reader verified the expense.

If you're paying at a register that's NOT set up to recognize eligible items, you'll need to use your own money and submit a claim to be reimbursed for the bandages and contact lens solution.

TIP: Save your itemized receipts.

If you're asked to verify an expense, you'll need to submit an itemized receipt.

How to get your expenses paid through Optum Financial

With Optum Financial, you have three ways to get your expenses paid through your Health Account and Health Care Flexible Spending Account (FSA), if you elect it:

Optum Financial payment card	Pay Provider	Reimburse Myself
You can use your debit card for most expenses. If Optum Financial asks you to verify an expense on your card, you'll need to submit an Explanation of Benefits (EOB) or itemized receipt.	Pay Provider sends money to your provider for amounts not paid by your health plan. Log in to your Optum Financial account and use Pay Provider. You'll need to upload your EOB or itemized receipt.	Download the free Optum Financial app for an easy way to use Reimburse Myself. Log in to your Optum Financial account and use Reimburse Myself if you already paid an eligible expense with your own money and you want to get reimbursed.

Optum Financial automatically debits your Health Care FSA first if you elected it; then your Health Account if you have one.

Don't have enough in your Health Care FSA or Health Account to cover the charge? You'll need to pay with your own money.

USE PAY PROVIDER OR REIMBURSE MYSELF FOR PRIOR-YEAR EXPENSES

If you're billed for a prior-year expense, use **Pay Provider** or **Reimburse Myself** to pay the claim. It's the safest way to make sure you won't have to repay a claim with your own money.

Don't use the Optum Financial payment card to pay for prior-year expenses unless you only have the Health Account. You may have to repay the claim with your own money.

What happens when you use your Optum Financial payment card?

Swipe your card

Optum Financial gets:

1. Amount swiped
2. Provider's name

Claims administrator sends information to Optum Financial

Optum Financial needs this information to verify the expense:

1. Date of service
2. Amount of service
3. Patient's name
4. Provider's name
5. Service provided

It's a match!

Your claim will be verified.

Oh no! It's not a match

Your claim won't be verified. You must provide your EOB or detailed receipt to Optum Financial.

EXAMPLES WHY:

- Different service dates
- Different payment amounts
- Missing information

TIP: Don't wait!

Send your Explanation of Benefits (EOB) to Optum Financial when you get it.

This will help you avoid:

- Followup requests for detailed receipts
- Having your card suspended and income added to your W-2 at the end of the year for unverified expenses that remain unverified after 180 days

DON'T USE THE OPTUM FINANCIAL PAYMENT CARD FOR PRIOR-YEAR EXPENSES

If you have the Health Care FSA and you use your Optum Financial payment card to pay a prior-year expense, **you'll have to repay the claim with your own money.** See page 86 for details.

Verifying expenses

Optum Financial will send reminders if you need to verify expenses you paid.

You'll have up to 180 days to verify your expenses. **After 180 days, if you haven't verified expenses and they total more than $150, Optum Financial will suspend your card.**

To verify your expenses were eligible, you'll need to provide your itemized receipts or Explanation of Benefits (EOB) statements. You can upload, mail or fax your documentation the same way you file claims.

Log in to your Optum Financial account to upload your documentation

Fax your documentation to **1-443-681-4602**

Mail your documentation to:
Optum Financial Claims Department
P.O. Box 622317
Orlando, FL 32862-2317

Unverified claims are taxable

If Optum Financial can't recover the full unverified amount of your claims, then the amount of your unverified claims will be added to your taxable income at the end of the year.

Repay your account to avoid extra taxable income

If you're unable to verify an expense and you want to avoid having the unverified amount added to your taxable income, you can repay your Health Account or Health Care FSA with the total unverified amount.

Log in to your Optum Financial account to find out how to repay your Health Account or Health Care FSA or call **1-866-271-8144** for instructions.

DON'T USE THE OPTUM FINANCIAL PAYMENT CARD FOR PRIOR-YEAR EXPENSES

If you have the Health Care FSA and the Health Account, it's best to use **Pay Provider** or **Reimburse Myself** to pay for prior-year expenses. Don't use your card because you may have to repay the claim with your own money.

Getting started with Optum Financial

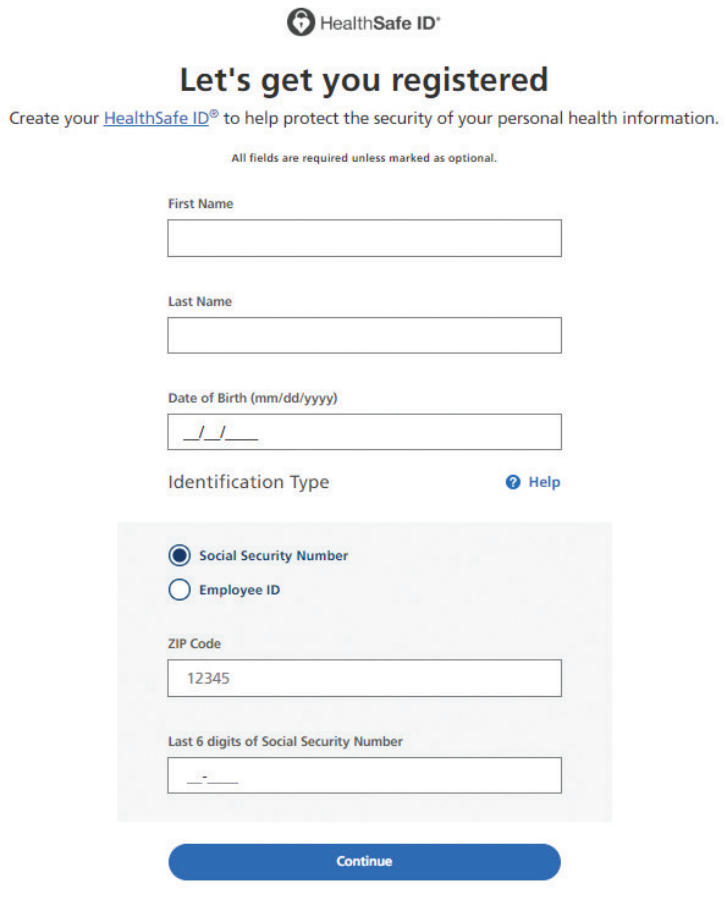
From myPlans Connect:

Log in to your myPlans Connect account and click **Access Your Health Account** under the **Your Health Insurance** box. You'll be able to go straight to your Optum Financial account without creating a username and password.

From OptumFinancial.com:

You'll need your Optum Financial payment card to access your account for the first time when logging in through **OptumFinancial.com**.

When accessing your account for the first time, you'll need to create a HealthSafe ID® username and password. HealthSafe ID adds an extra layer of security to your account by using two-factor authentication.



You're in control

Once you're signed in, you'll be able to:

- Activate your Optum Financial payment card for health expenses and manage your card—add and remove cardholders, replace cards and report cards as missing
- View account balances and transaction information
- Set up direct deposit for reimbursements to your personal bank account
- Set your personal communication preferences for the alerts and notices you wish to receive
- Enter new claims
- Register under Mobile Alerts for text messaging

On the go?

Managing and paying for eligible expenses is easy with the Optum Financial mobile app.

You'll be able to:

- View account balances and transaction information
- Upload and manage your receipts
- eCertify eligible dependent care expenses when you participate in the Dependent Care FSA
- Pay providers or reimburse yourself for eligible out-of-pocket expenses
- Get alerts for claims requiring attention

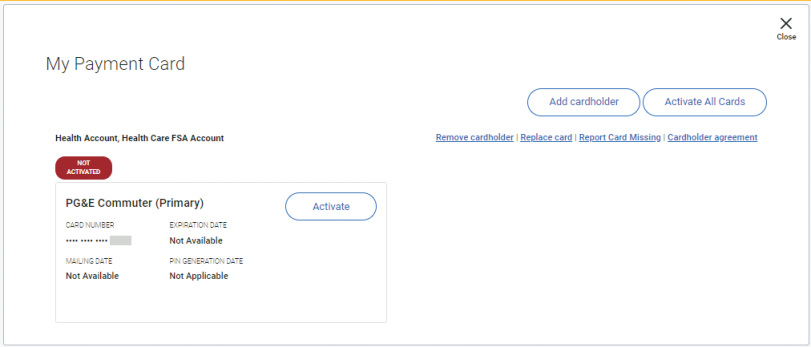
Download the free Optum Financial mobile app in the App Store or on Google Play.

Need extra cards?

After you receive your own card, you can order extra cards for family members.

- Log in to your Optum Financial account
- Click on the **My Payment Card** link
- Order as many cards as you like for free—with your name or your dependent's name on the card

The extra cards should arrive within 10 business days.



Need to remove a cardholder?

If a dependent is no longer eligible or you'd like to stop their access to your account, **you must call Optum Financial** to arrange for the dependent and their card to be removed from your account. PG&E does not have the ability to turn off access; only Optum can do this.

Payment options

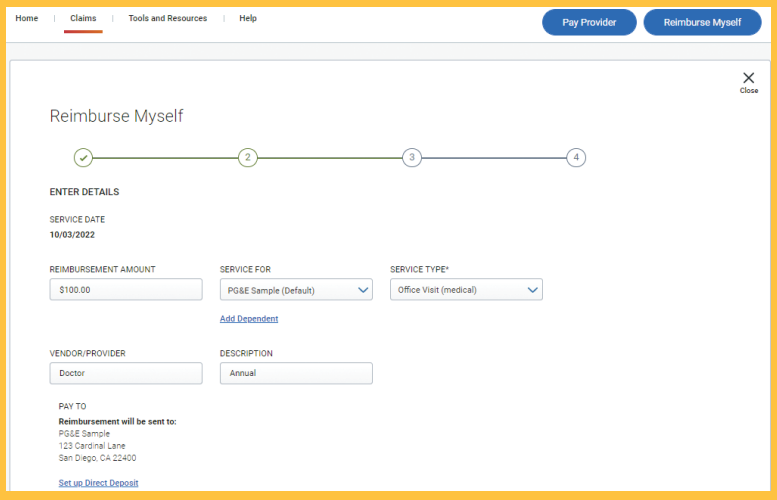
Need to pay your provider directly—or need to be reimbursed for health expenses you paid out of your pocket?

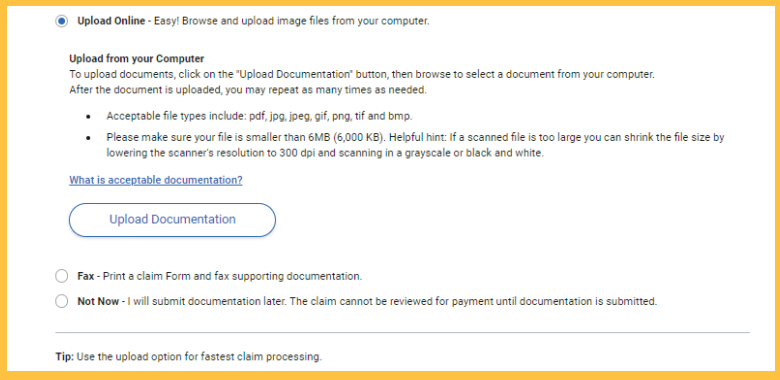
Optum Financial gives you easy options:

Use the **Pay Provider** option to have Optum Financial pay your doctor from an account you select

OR

Use the **Reimburse Myself** option if you've already paid an eligible expense out of your own pocket

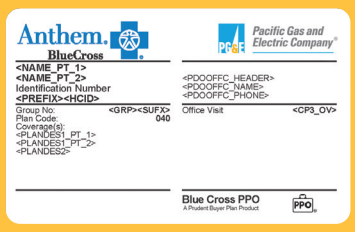


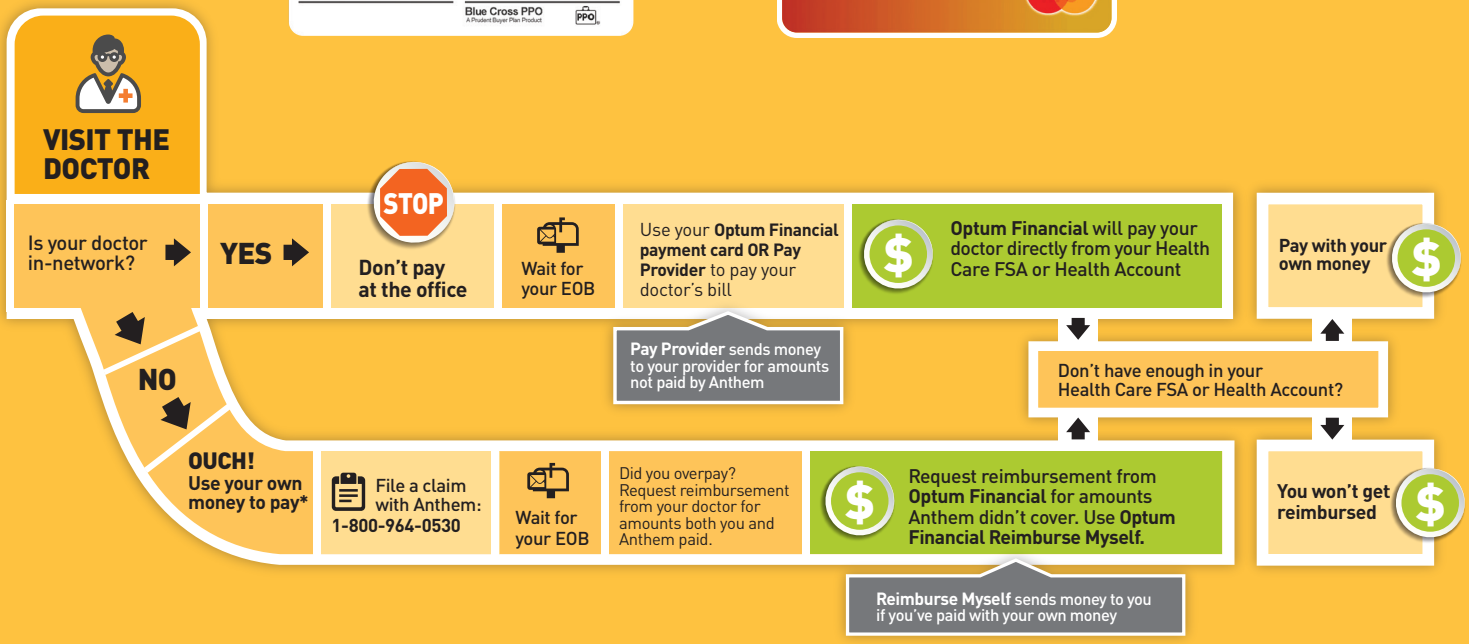


This is where you submit your Explanation of Benefits (EOB)

Paying for doctor visits

You'll need your Anthem ID card and your Optum Financial payment card.





***Using out-of-network doctors**

You can use your Optum Financial payment card at the time of service—but it's best to ask your out-of-network doctor to process your claim first and then bill you after your claim has been processed.

Most out-of-network doctors won't know exactly how much your benefit plan will pay.

If you use your **Optum Financial payment card** to pay your out-of-network doctor at the time of service

+

If your the Anthem HAP **also pays** the amount you've paid

THEN

You'll have to ask your out-of-network doctor for a refund

AND

You'll have to reimburse your Health Account or Health Care FSA

See page 91 for information about how to repay your Health Account or Health Care FSA to avoid extra taxable income.

Need help filing claims for out-of-network expenses?

Call Anthem: **1-800-964-0530**. Anthem representatives are available Monday–Friday, 7 a.m.–8 p.m. Pacific time.

Be careful using out-of-network providers—you'll usually pay more.

When you see that the Anthem HAP pays 80% of a covered charge for an out-of-network service, that means the HAP pays 80% of Anthem's maximum allowed amount for your region—not necessarily 80% of the total fees charged by the out-of-network provider.

The **maximum allowed amount** is the maximum charge Anthem will pay for covered services from health care providers.

For in-network providers:

The maximum allowed amount is based on negotiated fees with Anthem. In-network providers always accept the plan's maximum allowed amount, so you'll never have to pay additional amounts charged by the provider.

For out-of-network providers:

The maximum allowed amount is determined by Anthem. When an out-of-network provider charges more than the plan's maximum allowed amount, you're responsible for paying the difference.

NOTE: When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you're protected from surprise billing or balance billing. For more information, see the **No Surprises Act Notice** at **mypgebenefits.com > Resources > Legal Notices**.

With the Anthem HAP, you can use any provider you choose, but be careful. Out-of-network providers often charge more than the maximum allowed amount. You'll be responsible for paying the difference—which can be substantial.

If you need inpatient surgery or hospitalization, the out-of-network amounts you'll have to pay could be overwhelming—and these excess charges **don't count toward the annual deductible or out-of-pocket maximum.**

You can use the Health Account to help pay for these excess charges—but you'll use up your Health Account credits faster this way.

Want an example?

Let's say:

You use an out-of-network doctor for outpatient surgery **AND** You've already met your annual deductible, so the plan should pay benefits.

Here's how it works:

1

Anthem allows:	**$2,500**
But your out-of-network doctor charges more:	**$5,000**

2

You've already met the deductible, so the Anthem HAP pays 80% of the **maximum allowed amount:**	$2,000

80% of $2,500 = $2,000

3

You're responsible for the remaining 20% of the maximum allowed amount:	$ 500
AND	
You're responsible for 100% of the out-of-network charges that are above Anthem's maximum allowed amount:	$2,500

This $500 you pay counts toward your out-of-pocket maximum because it's your share of coinsurance (20%) toward Anthem's maximum allowed amount.

This $2,500 you pay DOES NOT COUNT toward your out-of-pocket maximum because it's not an eligible expense.

4

TOTAL YOU OWE:	**$3,000**
$500 toward Anthem's maximum allowed amount (your 20% coinsurance toward the $2,500 maximum allowed amount)	
+	
$2,500 to cover the out-of-network doctor's charges above Anthem's maximum allowed amount	

BOTTOM LINE:

Be ready to pay a lot when you use out-of-network providers.

FIND OUT HOW MUCH SERVICES COST

Log in to your **myPlans Connect** account and click on **(Resources)** at the top of the page, then **(Estimate Medical Plan Costs)**.

IF YOU GO OUT OF NETWORK, YOU MAY HAVE TO PAY FOR "FREE" SERVICES

When you go out-of-network, you may have to pay for services that are "free" when they're in-network—like your first four primary care visits.

EXAMPLE:

Let's say you go to an out-of-network doctor for one of your four free primary care visits—and your out-of-network doctor charges above Anthem's maximum allowed amount.

Here's how it works:

If Anthem allows **$90**—
and

Your out-of-network doctor charges **$130**—
then

Anthem will pay $90—but you'll have to pay the $40 that exceeds Anthem's maximum allowed amount.

The $40 you pay **will not count** toward your annual deductible or out-of-pocket maximum.

BOTTOM LINE:

You're better off using Anthem in-network providers because they'll never require payment beyond the maximum allowed amount.

USE ANTHEM'S SYDNEY HEALTH APP

Trying to find a doctor or an urgent care center?

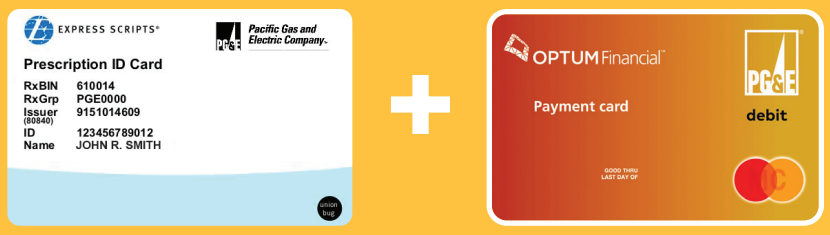
Sydney Health can help you find in-network providers and urgent care centers so you can be sure you're getting the best price for services.

You can also use Sydney Health to see claims, check benefits, view and use digital ID cards and use the chatbot to get answers quickly.

Paying for prescriptions

You can use your Optum Financial payment card when you buy prescriptions from an Express Scripts-participating pharmacy or when you use the mail-order program.

You'll need your Express Scripts ID card and your Optum Financial payment card when you visit an Express Scripts-participating pharmacy.



If you use a pharmacy that doesn't accept your Optum Financial payment card, you'll have to use your own money and then file a claim for reimbursement from your Health Account or Health Care FSA, if you elect it.

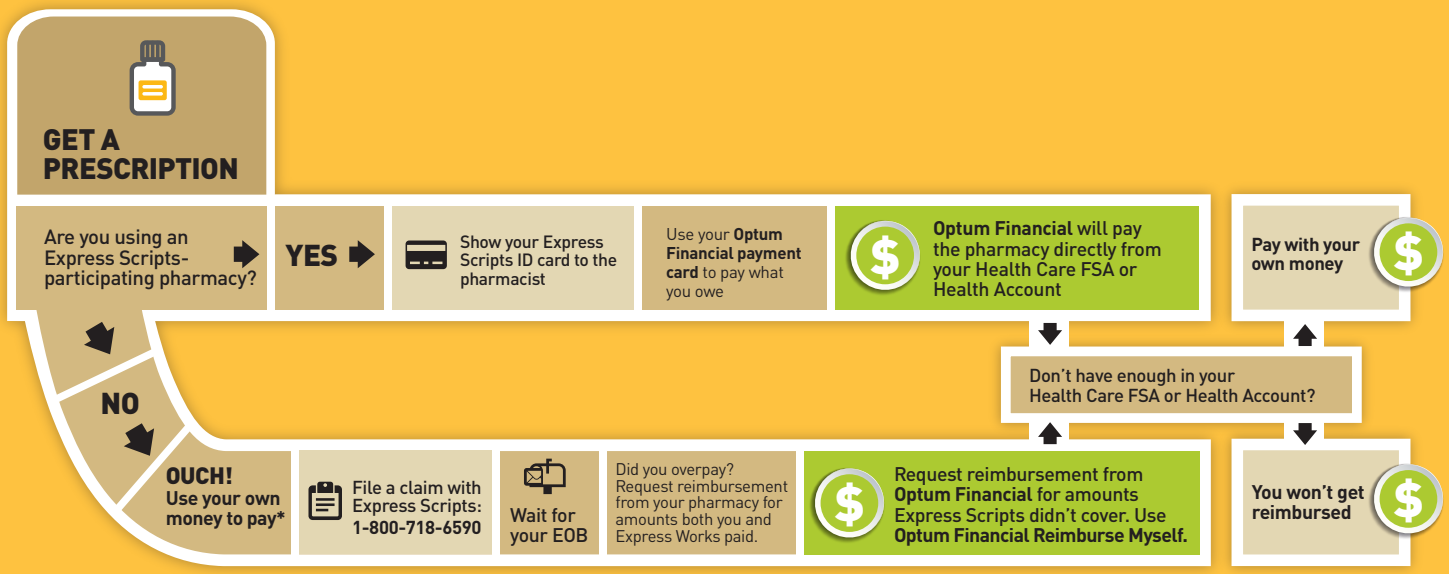
Stay safe: How to dispose of unused meds

Do you have unused or expired prescription medications? Protect yourself and your family members from accidental overdose by disposing of your meds safely:

DEA Take Back Day: Visit **takebackday.dea.gov** for the next Prescription Drug Take Back Day and drop-off locations.

Express Scripts disposal bags: Express Scripts will mail disposal bags to your home (visit **express-scripts.com**).

Cal Recycle: Find prescription drug disposal options at: **calrecycle.ca.gov/epr/pharmasharps/pharma/**.



*You can use your Optum Financial payment card at the time of service—but it's best to use your own money and wait for your Explanation of Benefits (EOB). That way, you won't have to repay your Health Account or Health Care FSA with amounts your insurance covers. See page 91 for details.

TIP: Keep your itemized receipts

Optum Financial may ask you to verify your pharmacy claims, so always keep your itemized receipts.

You'll have up to 180 days to verify your expenses. **After 180 days, if you haven't verified expenses and they total more than $150, Optum Financial will suspend your card.**

SOME PRESCRIPTION DRUGS ARE FREE

You can get select prescription drugs for free when you use the Express Scripts mail-order program.

To see which drugs are free, download the Express Scripts **Free Mail-Order Drug List** at **mypgebenefits.com > Physical Health > Medical - HAP Anthem**.

NEED THE PRICE OF MEDICATION?

Anthem members can look up how much drugs cost at Express Scripts-participating pharmacies by visiting **express-scripts.com**.

You'll be able to see how much your drug will cost both before and after the HAP's annual deductible has been met.

At the pharmacy

You can use any pharmacy for prescriptions, but you'll have lower costs when you use an Express Scripts-participating pharmacy. To find out if your pharmacy is an Express Scripts-participating pharmacy:

- Ask your pharmacy if it's an Express Scripts-participating pharmacy
- Call Express Scripts at **1-800-718-6590**
- Look up your pharmacy at **express-scripts.com** or on the Express Scripts mobile app

Express Scripts-participating pharmacies

- Express Scripts-participating pharmacies can tell you how much you owe under the HAP.
- Your prescription may cost less.

Other pharmacies

- Other pharmacies won't know how much you owe under the HAP.
- Your prescription may cost more.
- You might not be able to use your Optum Financial payment card. Some small, independent pharmacies don't have the necessary computer systems to validate your transaction.
- You'll probably be required to pay 100% up front, and you'll have to file a claim for reimbursement with Express Scripts.

USE THE EXPRESS SCRIPTS APP

Want to manage your prescriptions on the go?

Use the mobile app to log in to your Express Scripts account. You can:

- Request refills and renewals
- Track your mail-order prescriptions
- Look up lower-cost options
- View your medications and set reminders
- Get personalized alerts about possible drug interactions
- Display your virtual Express Scripts ID card

By mail

You can get up to a 90-day supply of medication for each prescription when you use the Express Scripts mail-order program.

Your prescription may cost less than it would at a retail pharmacy.

You can use your Optum Financial payment card.

The first time you place an order with Express Scripts, you'll need to complete a health assessment questionnaire in addition to the mail-order form. You'll need to mail the completed forms with your original prescription to:

Express Scripts, HMQ Processing Center, P.O. Box 14238, Lexington, KY 40512-4238

To get the Express Scripts mail-order form, health assessment questionnaire and mail-order envelopes:

- Call Express Scripts Member Services at **1-800-718-6590**
- Download the mail-order form and health assessment questionnaire at **express-scripts.com**

You can also download the mail-order form and health assessment questionnaire at **mypgebenefits.com**, but you need to call or log in to Express Scripts to request the mail-order envelope.

Maintenance medication

You must use the Express Scripts mail-order program for certain maintenance medications.

To download the Express Scripts Mandatory Mail-Order Maintenance Drug List, go to **mypgebenefits.com > Physical Health > Medical - HAP Anthem**.

You can get up to three fills of the same maintenance drug from a retail pharmacy before you have to switch to mail order. If you don't switch to mail order after three fills, you'll have to pay 100% of the cost at the pharmacy—and this does not apply to your deductible or out-of-pocket maximum.

Most narcotics, ADHD drugs and compound drugs are not part of the mandatory mail-order requirement; you can purchase these at a retail pharmacy.

Paying for dental and vision expenses

You can use your Optum Financial payment card at the time of service—but it's best to ask your dentist or eye doctor to process your claim first and then bill you after your claim has been processed.

Most providers won't know exactly how much your benefit plans will pay.

If you use your **Optum Financial payment card** to pay your dentist or eye doctor at the time of service

+

If your dental or vision plan **also pays** the amount you've paid

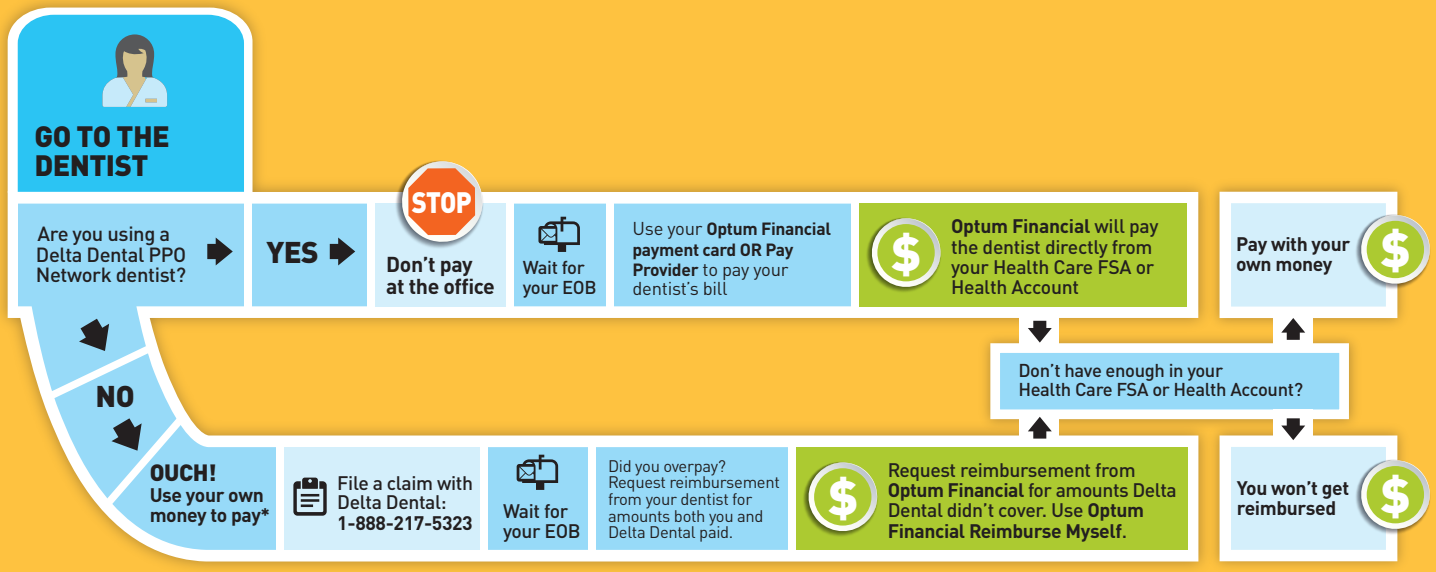
THEN

You'll have to ask your provider for a refund

AND

You'll have to reimburse your Health Account or Health Care FSA

See page 91 for information about how to repay your Health Account or Health Care FSA to avoid extra taxable income.



*Did you overpay?

If your dentist or eye doctor requires you to pay the full amount at the time of service, keep track of how much you pay versus how much your insurance pays. You'll need to seek reimbursement from your dentist or eye doctor for the amount paid by your insurance if you paid that amount, too.

If you used your Optum Financial payment card to pay at the time of service, you'll need to repay your Health Account or Health Care FSA with the amount your dentist or eye doctor reimbursed. See page 91 for details.

TIP

It's best to ask your dentist or eye doctor to first file a claim with your insurance and then bill you for any amount not covered.

Paying for mental health and substance use disorder care

Carelon Behavioral Health administers all mental health and substance use disorder services for Anthem HAP members.

To preauthorize care, contact a Carelon Behavioral Health care manager at 1-888-445-4436.

FOR MAXIMUM BENEFITS, USE IN-NETWORK PROVIDERS

Use Carelon Behavioral Health network providers to get the maximum benefit. Out-of-network providers often charge more than the maximum allowed amount. You'll be responsible for paying the difference—or for paying the full cost of expenses that are ineligible. These amounts can be substantial.

Talk to your provider before getting care to understand your share of the cost.

How to preauthorize Applied Behavioral Analysis services (autism treatment)

Carelon Behavioral Health provides Applied Behavioral Analysis (ABA) services at no charge, with no deductible.

To preauthorize or precertify treatment, call Carelon Behavioral Health at 1-888-445-4436. During this call, a care manager will request basic information—including, but not limited to:

- A child's diagnosis
- Who made the diagnosis
- What the presenting symptoms are (for example, developmentally delayed skills, problem behaviors).

Getting reimbursed for mental health and substance use disorder care

After you receive care from a Carelon Behavioral Health provider, you'll need to wait a few weeks for Carelon Behavioral Health to process your claim, determine what you owe and mail you an Explanation of Benefits (EOB) form.

After you get your EOB, you can use your Optum Financial payment card to pay your provider the amount you owe—as long as you have enough in your Health Account or Health Care FSA.

Kaiser Permanente members

You'll get the Kaiser Permanente health payment card if you elect the Kaiser Permanente HAP.

Here's how the Kaiser Permanente health payment card works:

Health Account credits	Your card will be loaded with your annual Health Account credits. Any leftover balances from the current year will be available at the start of the next year.
Health Care FSA contribution	**If you elect the Health Care FSA,** your card will be loaded with your annual FSA contribution and any applicable carryover amounts.*
Medical expenses	When you go to a Kaiser Permanente doctor, you don't need to do anything to get reimbursed for medical expenses. Kaiser Permanente automatically processes these expenses through your Health Account or Health Care FSA so you don't need to use your Kaiser Permanente health payment card or file a claim for reimbursement.
Prescriptions	You can use the card at Kaiser Permanente pharmacies. You may be able to use the card at other pharmacies, but be sure to save your itemized receipt in case you're asked to verify your expenses.
Dental and vision expenses	You can use the card to pay for dental and vision expenses when you check in for your appointment or when you get a bill. You'll have to submit your Explanation of Benefits (EOB), bill or itemized receipt to verify your expenses.
Over-the-counter purchases	You can use the card for eligible over-the-counter items such as bandages and contact lens solution. You may need to submit your itemized receipts to verify your expenses. For a list of eligible over-the-counter items, visit **irs.gov** and look for **Publication 502**.

*You can use the card **ONLY** for current-year expenses. If you don't contribute to the Health Care FSA for 2024 but you have a carryover balance from 2023, you can use the card to pay for eligible health expenses incurred in 2024.

Kaiser Permanente reimbursement rules

There are two things you need to know about getting reimbursed through Kaiser Permanente:

1 Claims filing and expense verification deadline

2 When you can use your Kaiser Permanente health payment card

Getting reimbursed	Health Care Flexible Spending Account (FSA)	Health Account
1 What's the latest you can file a claim and verify an expense?	June 30 for expenses incurred through December 31 of the prior year	No deadline for active participants
2 Can you use your Kaiser Permanente health payment card?	Pay for care with your debit card when you check in for a visit at the dentist or eye doctor, or when you get a bill. You can use your card for prescription drugs at Kaiser Permanente pharmacies and at other pharmacies. You can even use the card for eligible over-the-counter items, such as bandages and contact lens solution. Kaiser Permanente may ask you to submit an Explanation of Benefits (EOB), bill or itemized receipt to verify your expenses. If you haven't verified your expenses after 180 days, **Kaiser Permanente will suspend your card**.	

VERIFYING EXPENSES

Kaiser Permanente will send reminders if you need to verify your expenses. You'll need to log in to your account at **kp.org/healthexpense** and click **File a Claim**. Then follow the required steps.

To verify your expenses were eligible, you'll need to provide an Explanation of Benefits (EOB), bill or itemized receipt.

You'll have up to 180 days to verify expenses. **If you haven't verified your expense after 180 days, Kaiser Permanente will suspend your card.**

Using your card for over-the-counter purchases

Many retailers—especially big-box retailers with pharmacies—can automatically verify many eligible health expenses, so you won't have to submit itemized receipts.

TIP: Pay at the pharmacy register.

Try to use the pharmacy register when you're shopping—especially when you're at a big-box retailer that has a pharmacy.

Pharmacy registers are typically set up to recognize eligible items and will accept the card. Front registers might reject the card.

EXAMPLE:

You're shopping at a big-box store and you're buying bandages, contact lens solution and toilet paper.

If you're paying at a register that recognizes eligible items, the card will work for the bandages and contact lens solution, but it will reject the toilet paper, so you'll have to pay for that with your own money.

You won't have to submit a claim for the bandages and contact lens solution because the card reader verified the expense.

If you're paying at a register that's NOT set up to recognize eligible items, you'll need to use your own money and submit a claim to be reimbursed for the bandages and contact lens solution.

TIP: Save your itemized receipts.

If you're asked to verify an expense, you'll need to submit an itemized receipt.

How to file a claim through Kaiser Permanente

There are two paths to getting your expenses paid through the Health Care FSA and Health Account.

From kp.org	From kp.org/healthexpense
• Log in with your Kaiser Permanente username and password • Click on **Billing** • Under **Health Payment Accounts**, click on **View Accounts** • Follow the remaining steps below	• Log in with your Kaiser Permanente username and password • Follow the remaining steps below

- Click on **Reimburse Myself** or **Send Payment**
- Follow the prompts on the **menu screen** to submit your claim

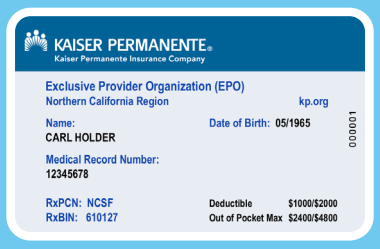
You'll need to upload your **itemized receipt or EOB** and enter the date of service, amount of service, provider's name, patient's name and service provided in order to verify your expense.

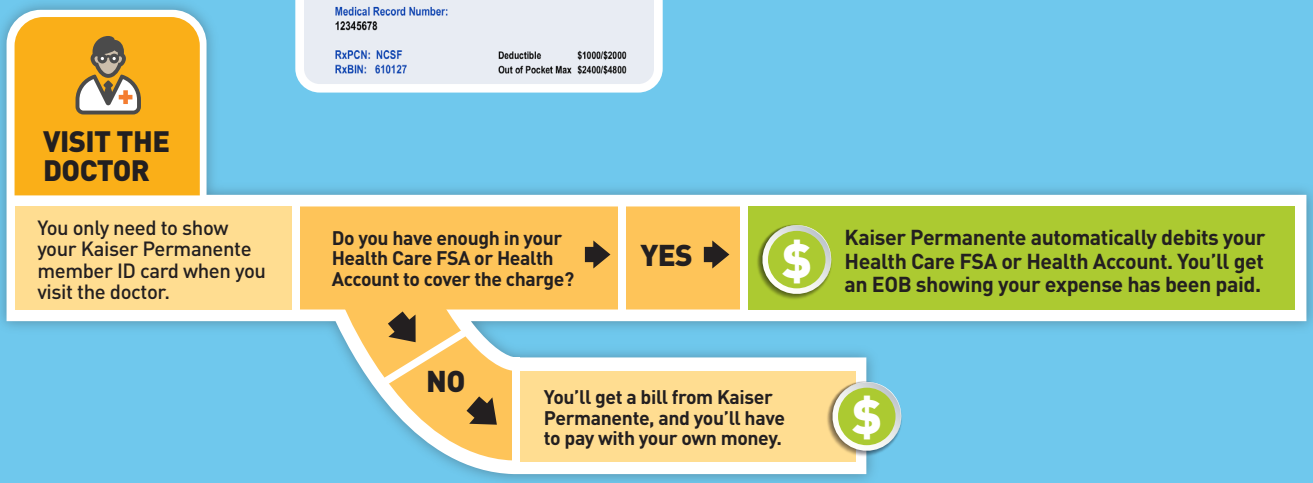
Kaiser Permanente automatically debits your Health Care FSA first if you elected it; then your Health Account.

TIP **To verify your expenses were eligible, you'll need to provide an Explanation of Benefits (EOB), bill or itemized receipt.**

Paying for doctor visits

You'll need your Kaiser Permanente member ID card.





Be ready to cover the bill for some services.

Your first four primary care doctor visits are free—but please note that free doctor visits may include lab tests or other services. Those tests and services may be covered but they may not be free.

Want to know what services are free?

Visit **mypgebenefits.com > Physical Health > Medical - HAP Kaiser** for a list of free services.

Find out how much services cost

Log in to your **myPlans Connect** account and click on **(Resources)** at the top of the page, then **(Estimate Medical Plan Costs)**.

You can also log in to **kp.org** and check the Sample Fee List or go to: **kp.org/treatmentestimates**.

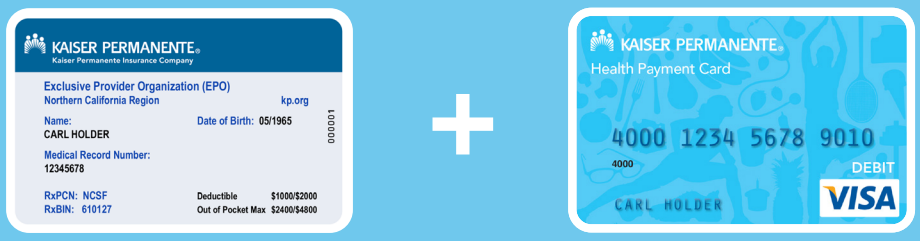
TIP Log in to see your Health Account balance: **kp.org/healthexpense**

TRACK YOUR SPENDING ON THE GO

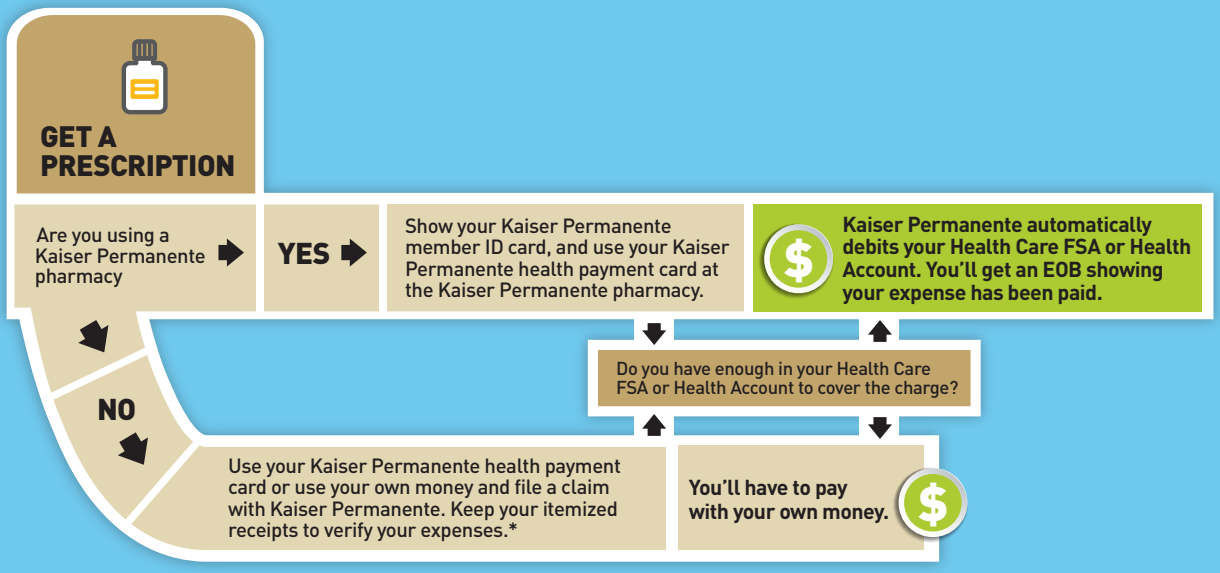
Use the **KP HRA/HSA/FSA Balance Tracker** app to see your health care spending and to file claims for reimbursement from your Health Account or Health Care FSA, if you elect it.

Paying for prescriptions

You'll need your Kaiser Permanente member ID card and your Kaiser Permanente health payment card when you visit the Kaiser Permanente pharmacy:



You can use your Kaiser Permanente health payment card to pay your share of the cost of prescriptions from your Health Account or Health Care FSA, as long as you have enough in your account.*



*You can use your Kaiser Permanente health payment card for **out-of-network prescriptions**—but it's best to use your own money and wait for your Explanation of Benefits (EOB). That way, you won't have to repay your Health Account or Health Care FSA with amounts your insurance covers. See page 117 for details.

USING THE CARD FOR OVER-THE-COUNTER PURCHASES

See page 110 for tips on how to use your card for over-the-counter purchases.

For prescriptions within Kaiser Permanente: You can get your prescription at the pharmacy or by mail.

Kaiser Permanente pharmacy

- Use your Kaiser Permanente health payment card to pay for prescriptions.
- The pharmacy will charge exactly how much you owe.
- You'll get a receipt with the exact cost.

Mail order

Log in to your Kaiser Permanente account at **kp.org/rxrefill** to order prescriptions by mail.

Some mail-order drugs are free. Visit **mypgebenefits.com** > **Physical Health** > **Medical - HAP Kaiser** for a list of free mail-order drugs.

Refills

You can order refills:

- By calling or visiting your Kaiser Permanente pharmacy
- Through Kaiser Permanente's mail-order service
- Through Kaiser Permanente's website at **kp.org/rxrefill**

Maintenance medication

You can order refills from a Kaiser Permanente pharmacy, through Kaiser Permanente's mail-order service or through Kaiser Permanente's website at kp.org/rxrefill.

You don't have to use mail order for maintenance/chronic condition medication from Kaiser Permanente.

Stay safe: How to dispose of unused meds

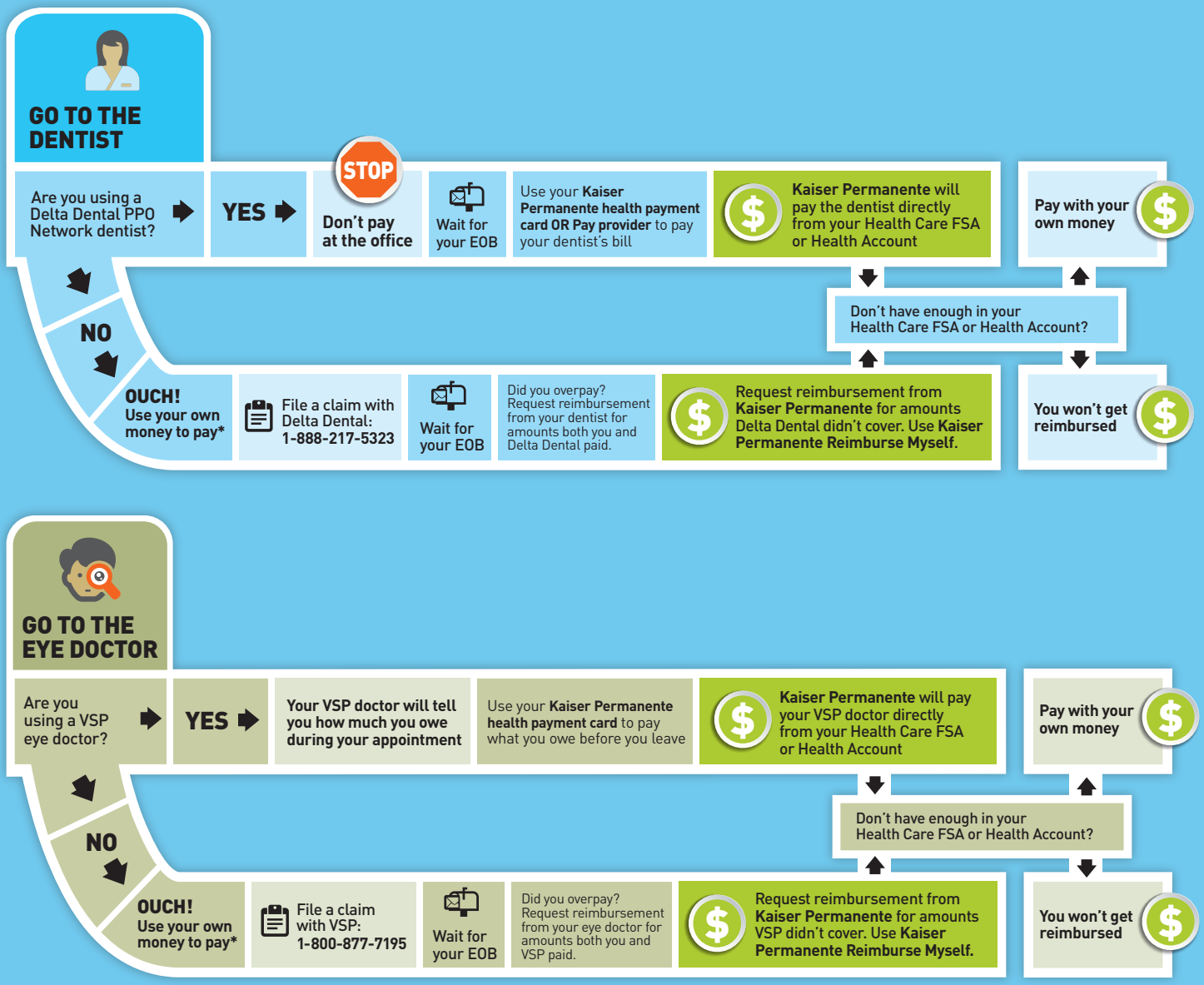
Do you have unused or expired prescription medications? Protect yourself and your family members from accidental overdose by disposing of your meds safely:

DEA Take Back Day: Visit **takebackday.dea.gov** for the next Prescription Drug Take Back Day and drop-off locations.

Kaiser Permanente kiosks: Visit **kp.org/facilities** for locations of secure collection kiosks in some Kaiser Permanente pharmacy lobbies.

Cal Recycle: Find prescription drug disposal options at: **calrecycle.ca.gov/epr/pharmasharps/pharma/**.

Paying for dental and vision expenses



*Using your Kaiser Permanente health payment card

You can use your Kaiser Permanente health payment card at the time of service—but it's best to use your own money and wait for your Explanation of Benefits (EOB). That way, you won't have to repay your Health Account or Health Care FSA with amounts your insurance covers. See page 117 for details.

Paying for care

Regardless of how you pay, you'll need to submit your itemized receipts and Explanation of Benefits (EOB) statements to Kaiser Permanente to verify your expenses.

You'll have up to 180 days to verify expenses. **If you haven't verified your expense after 180 days, Kaiser Permanente will suspend your card.**

It's best to ask your dentist or eye doctor to process your claim first. After you get your EOB, your dentist or eye doctor will bill you for any amount you owe. You can use your card or spend your own money to pay the bill.

If your dentist or eye doctor requires you to pay at check-in, you can use your Kaiser Permanente health payment card or you can spend your own money.

TIP

Don't overpay

If your dentist or eye doctor requires you to pay the full amount at the time of service, keep track of how much you pay versus how much your insurance pays. You'll need to seek reimbursement from your dentist or eye doctor for the amount paid by your insurance if you paid that amount, too.

It's best to ask your dentist or eye doctor to first file a claim with your insurance and then bill you for any amount not covered.

Repaying your Health Account or Health Care FSA

If you used your Kaiser Permanente health payment card to pay at the time of service, you'll need to repay your Health Account or Health Care FSA with the amount your dentist or eye doctor reimbursed. Contact Kaiser Permanente to find out how to repay your Health Account or Health Care FSA.

Paying for mental health and substance use disorder care

Kaiser Permanente provides most mental health services for its members.

You can use Carelon Behavioral Health or Kaiser Permanente for inpatient substance use disorder treatment. All inpatient substance use disorder treatment requires preauthorization.

KAISER PERMANENTE MENTAL HEALTH RESOURCES

Visit **kp.org/mentalhealth** for Kaiser Permanente mental health resources, including contact information, virtual training, webinars, health classes, toolkits, apps and more.

To preauthorize Carelon Behavioral Health care, contact a Carelon Behavioral Health care manager at 1-888-445-4436.

Special rules for Applied Behavioral Analysis services (autism treatment)

Both Kaiser Permanente and Carelon Behavioral Health provide Applied Behavioral Analysis (ABA) services at no charge, with no deductible.

You don't need to preauthorize care from Kaiser Permanente. If you're using Carelon Behavioral Health, you'll need to preauthorize or precertify care by calling Carelon Behavioral Health at **1-888-445-4436**. During this call, a care manager will request basic information—including, but not limited to:

- A child's diagnosis
- Who made the diagnosis
- What the presenting symptoms are (for example, developmentally delayed skills, problem behaviors)

Getting reimbursed for substance use disorder care and Applied Behavioral Analysis (ABA) services

Inpatient detox and substance use disorder care

After you receive inpatient detox or substance use disorder care from Carelon Behavioral Health, your Carelon Behavioral Health claim will be processed through Kaiser Permanente. Any amount you still owe will be paid to your provider from funds in your Health Account or Health Care FSA. If you don't have enough in these accounts to pay what you owe, you'll be billed.

Applied Behavioral Analysis (ABA)

After you receive ABA treatment from Carelon Behavioral Health, your Carelon Behavioral Health claim will be processed through Kaiser Permanente. ABA is covered at 100% with no deductible required, so your claim will be paid in full even if you have no funds in your Health Account or Health Care FSA.

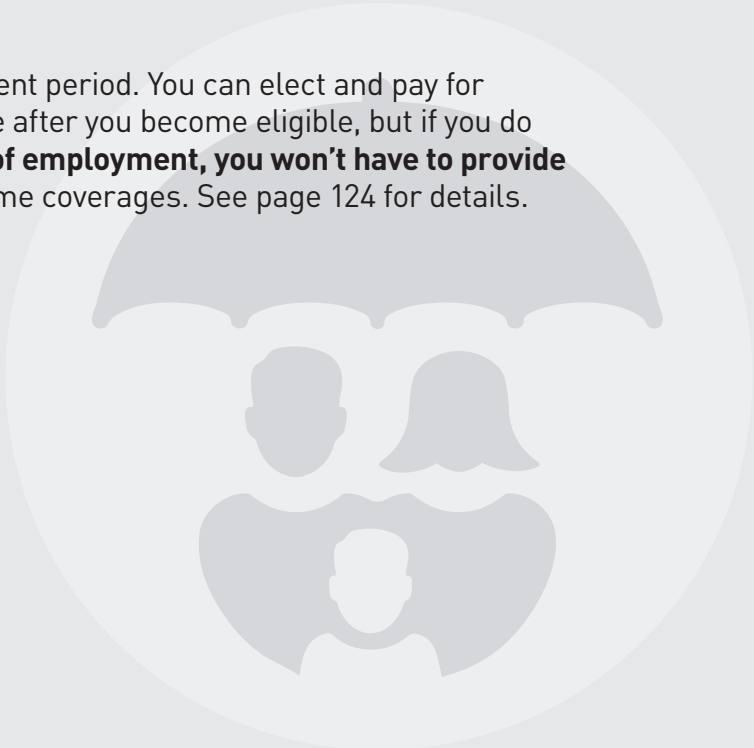
Life and accident insurance

Insured by MetLife

Life and accident insurance gives you financial protection by paying a benefit if you die or are seriously injured in an accident.

To help you provide financial security for your loved ones in the event of your death or serious injury, PG&E automatically provides Basic Life and Basic Accidental Death & Dismemberment (AD&D) coverage at no cost to you.

There is no special enrollment period. You can elect and pay for additional coverage anytime after you become eligible, but if you do so **within the first 90 days of employment, you won't have to provide proof of good health** for some coverages. See page 124 for details.



Your coverage when eligible

When you become eligible for coverage, PG&E automatically provides $10,000 of Basic Life and $10,000 of Basic Accidental Death & Dismemberment (AD&D) coverage at no cost to you.*

You can request to buy Supplemental Life, Dependent Life and Voluntary AD&D coverage at any time during the year through myPlans Connect.

Management, A&T and PG&E Corporation employees:
You're eligible immediately.

Union-represented employees:
You're eligible after you have six months of service and you attain regular status.

*Directors/Chiefs and above receive $250,000 of Basic AD&D at no cost.

Elect your beneficiary

You'll need to elect your beneficiary for your PG&E-paid Basic Life and Basic AD&D insurance:

Log in to your myPlans Connect account

OR

Call the PG&E Benefits Service Center

This is a separate election from your 401(k) and pre-retirement pension beneficiary elections. Your beneficiary elections for one benefit won't carry over to another benefit.

You can elect or change life and accident coverage anytime

You can enroll or change life and accident coverage anytime after you become eligible for coverage. Log in to your myPlans Connect account to enroll, change coverage, check your current coverage details or update your beneficiary.

How much coverage do you need?

Your insurance needs change as your life changes—for example, when you marry, start a family or buy a house.

Log in to your myPlans Connect account at **mypgebenefits.com** and use the life insurance calculator to see how much insurance you need to keep your family secure.

Do you have family members who depend on you financially—spouse, children, elderly parents?

PG&E-sponsored life and accident insurance can help you better protect your family's financial health. After all, the more people who depend on you, the more coverage you may need to help your family keep the household running:

- Mortgage or rent payments
- Insurance premiums
- Transportation
- Utilities
- Child care/education fees
- Credit card bills

Your choices

Supplemental Life	Within 90 days of becoming eligible	Anytime after first 90 days of eligibility
Union-represented employees*	• You can elect coverage up to two times your annual base pay without proof of good health. • You can request coverage in the amount of three to six times your pay (maximum $1 million) with a full statement of health.**	
Management, A&T and PG&E Corporation employees*	You can elect coverage up to six times your pay (maximum $4 million) without proof of good health.	• You can elect coverage up to two times your pay without proof of good health. • You can request coverage in the amount of three to six times your pay (maximum $4 million) with a full statement of health.**

Dependent Life	Within 90 days of becoming eligible	Anytime after first 90 days of eligibility
Spouse or domestic partner coverage***	• You can elect coverage up to $25,000 without proof of good health. • You can request coverage up to $100,000 with a full statement of health.**	You'll need to provide a full statement of health** to request any amount of coverage up to $100,000.
Child coverage	You can elect coverage up to $25,000 without proof of good health.	

*If you're changing from one type of employee to the other, rates may change. To see rates, go to **mypgebenefits.com > Financial Health > Life and Accident Insurance**.

**A full statement of health may include answering health questions and taking a physical exam.

***To elect Dependent Life coverage for your eligible spouse or domestic partner, you must also elect Supplemental Life Insurance coverage for yourself. The coverage amount for your spouse or domestic partner cannot be more than 50% of your total Basic and Supplemental Life Insurance coverage amounts.

Voluntary AD&D	As soon as you're eligible and anytime thereafter
Union-represented employees	You can elect coverage up to six times your pay for you only or for you and your dependents (maximum $1 million for employees, $500,000 for spouses and $150,000 for children).
Management, A&T and PG&E Corporation employees	You can elect coverage up to six times your pay for you only or for you and your dependents (maximum $2 million for employees, $1 million for spouses and $300,000 for children).

Low costs for Voluntary AD&D

You can get a lot of protection for a little money with Voluntary AD&D insurance.

You pay just two cents for every $1,000 of coverage for yourself, and three cents for every $1,000 of coverage for the Family Protection Plan Plus (you and your dependents).

That works out to about $4.50 per month for $150,000 of coverage under the Family Protection Plan Plus.

You can enroll anytime with no health questions or physical exam.

Extra benefits with Supplemental Life insurance

When you enroll in Supplemental Life insurance, you have access to these services free of charge:

Will preparation services

You can access MetLife Legal Plans' network of 11,500+ participating attorneys to prepare a will, testamentary trust and power of attorney. These services are available at no charge when you use a participating network attorney. An out-of-network reimbursement option is also available. Call MetLife Legal Plans at **1-800-821-6400** to access this benefit.

Estate resolution services

Your family can use MetLife Legal Plans' Estate Resolution Services at no charge. A MetLife Legal Plan attorney will consult with your beneficiaries by phone or in person about the probate process for your estate. The attorney also will handle the probate of your estate for your executor or administrator. For more information:

Visit **legalplans.com/estateplanning**

OR

Call MetLife Legal Plans at **1-800-821-6400**.

Grief counseling services

You and your beneficiaries can use MetLife's grief counseling services, which include personalized counseling sessions.

Funeral discounts and planning services

Through MetLife Advantages℠, you and your family can use Dignity Memorial's funeral discount and planning services at no charge:

- Pre-negotiated discounts of up to 10% off of funeral, cremation and cemetery services
- Planning services to help you and your family manage final wishes
- Bereavement travel services to help with time-sensitive travel arrangements to be with loved ones

Expert assistance is available 24 hours a day, 7 days a week, 365 days a year—to help guide you and your family in making confident decisions. Visit **finalwishesplanning.com** or call **1-866-853-0954**.

Trusts and estate planning through the EAP

Contact the Employee Assistance Program (EAP) at **pge.mybeaconwellbeing.com/legal** or call **1-888-445-4436** to request a trusts and estates attorney in your area. There is no charge for the first consultation, and you'll get a discount on fees if you continue to use their services.

Travel Assistance

Domestic Business Travel Insurance

Business Travel insurance is available for employees who regularly work a minimum of 30 hours per week and are traveling for work, including aircraft operations (helicopter insurance is described on page 128).

- You automatically get three times your annual base pay up to a maximum of $1 million in Business Travel Insurance coverage while traveling on company business.
- PG&E provides this coverage at no cost to you. New York Life administers this benefit.

Planning an international trip?

PG&E's International Business Travel Plan gives you access to Aetna WorldTraveler. These services are available at no cost to you.

Call WorldTraveler if:

- You're planning a trip and need general travel information
- You need medical assistance while traveling
- You lose documents, credit cards or luggage while traveling
- You require medical evacuation
- You experience local language problems
- You want to request the theft and resolution guide
- You're a victim of identity theft and you need personal help

TIP **If you're eligible for this service, you'll receive an Aetna WorldTraveler card with contact information and details about how to register.**

Helicopter insurance

In the event of serious injury or fatality

The safety of PG&E's employees is top priority, but if the unthinkable happens—a serious injury or fatality while performing job duties riding in a helicopter—PG&E provides special coverage.

Any employee riding in a helicopter while performing job duties gets automatic helicopter insurance coverage:

- $2 million of accidental death and dismemberment (AD&D) coverage—up to an aggregate of $6 million per incident.
- Helicopter policies are available through Zurich ($1 million coverage) and W. R. Berkley Corporation ($1 million coverage).

You don't need to do anything to get this coverage; it's automatic.

Helicopter insurance coverage is **in addition to** other insurance coverage, including Business Travel, Voluntary AD&D, Supplemental Life and Workers' Compensation.

Questions?

CALL

Call the PG&E Benefits Service Center at **1-866-271-8144** Monday–Friday, 7:30 a.m.–5 p.m. Pacific time.

EMAIL

Log in to your **myPlans Connect account** and send a secure message to a service representative. You'll get a reply within three business days.

CHAT

Log in to your **myPlans Connect account** and chat online with a service representative Monday–Friday, 7:30 a.m.–5 p.m. Pacific time.

You can also chat 24/7 with **Ava**, the digital assistant.

Have a question? Chat with Ava.

Log in to **myPlans Connect** for 24/7 access to Ava, PG&E's artificial intelligence (AI) app.

You can ask questions and Ava will respond or give you directions on where to find more information.

Work/life benefits

PG&E offers a range of benefits designed to make life a little easier.

Commuter Transit Program

Administered by Optum Financial

The Commuter Transit Program lets you pay for transit products and services and commute-related parking expenses with before-tax contributions deducted from your pay, potentially reducing your taxable income and saving you money.

Want to participate?

You can enroll anytime through Optum Financial but **the cutoff is the fifth of the month** for benefits to be ready the following month.

You can use your contributions only for eligible transportation costs.

Getting started

You'll need to set up your Optum Financial Commuter Transit account before you can enroll.

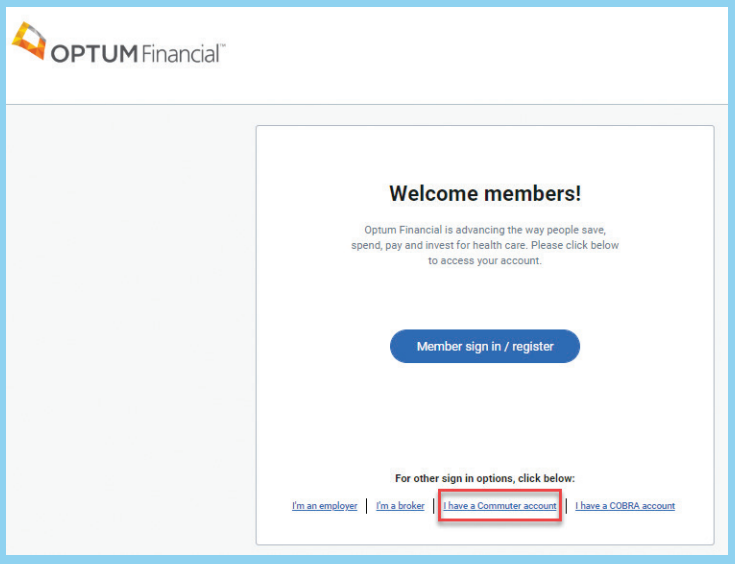
From myPlans Connect:

When you log in to MyPlans Connect, you'll be able to go straight to your Optum Financial Commuter Transit account without creating a username and password.

Go to **Maximize Your Health > Learn More & Sign Up**.

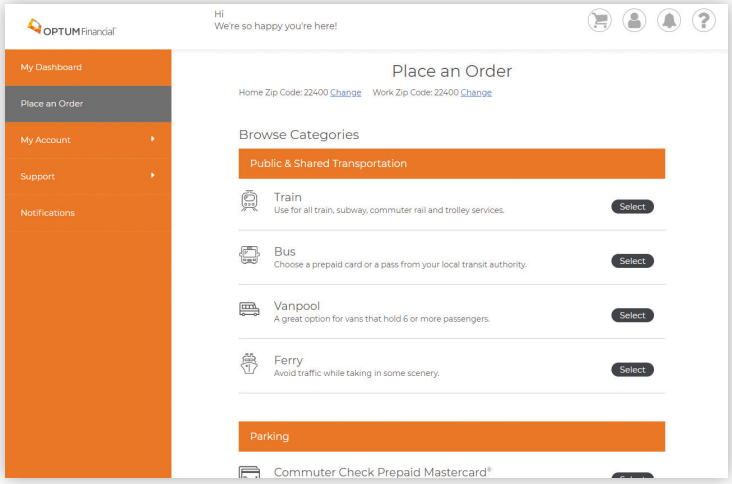
From OptumFinancial.com:

When accessing your Commuter Transit account for the first time, you'll need to register your account.



Commuter transit and parking options

Once you're logged in to the Optum Financial Commuter Benefits Dashboard, you'll be able to select the transit and parking options you need.



Commuter payment card

Optum Financial offers one commuter payment card to cover all your commuter needs, from transit to parking.

If you order the **Prepaid Card**, it should arrive in your mail by the end of the month. It will be ready to go on the first of the following month.

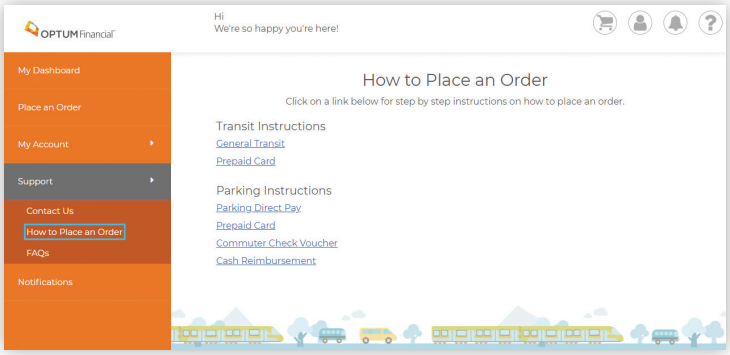
NOTE: The cutoff for ordering is the fifth of the month.

How to place an order

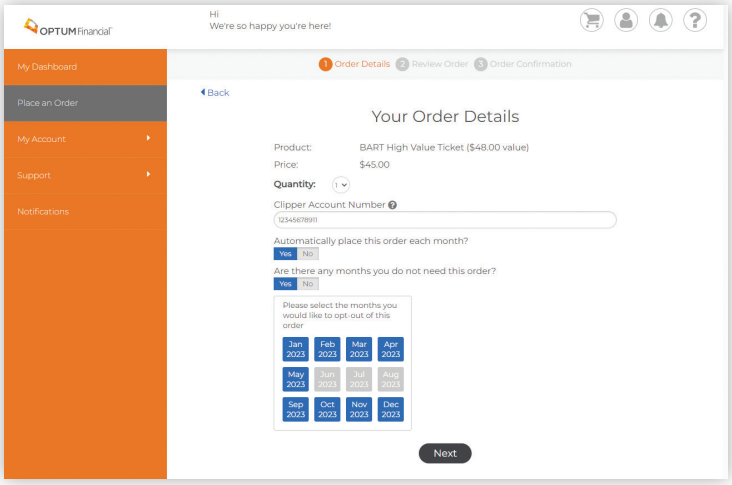
The Optum Financial Commuter Benefits Dashboard makes ordering easy. You can choose from the following options:

- Set up your account for recurring monthly orders
- Select which months you want recurring orders
- Order manually each month

Click the link you want and follow the steps:



You'll be able to see and change your order details:



ESTIMATE CAREFULLY

Even though there's a single Optum Financial commuter payment card, **parking** and **transit** are **separate funds**.

This means you can't switch money from one fund to the other after your order is finalized.

Time off

Everyone needs time off to recharge. PG&E provides a variety of time off options for diverse needs.

Time off	Union-represented employees	Management and A&T employees	PG&E Corporation employees
Vacation	You're eligible to use your accrued vacation after you have six months of service and attain regular status.* • Your accrual rate for vacation is based on your years of service. • You may carry over unused vacation up to a maximum of two times your annual vacation accrual rate. • IBEW- and SEIU-represented employees start accruing up to 80 hours per year.** • ESC-represented employees start accruing up to 120 hours per year.**	You're eligible to accrue and begin using vacation on your first day at work. • Your accrual rate for vacation is based on your years of service. • The maximum amount of vacation you may accrue (the cap) is twice the annual vacation maximum. This includes any unused vacation that is being carried over. • You will not accrue additional vacation until the balance falls below the maximum of two times your annual vacation accrual rate.	Paid time off (PTO) applies. See page 135.
Sick pay	**Incidental Sick Time for Management, A&T and ESC-represented employees:** • Accrue eight hours per month.** • Accrual is awarded on the first calendar day of each month. • Sick time accrues up to a maximum of 96 hours and carries over to the following year. **IBEW- and SEIU-represented employees (after one year of service, regular-status employees are eligible for the following):** • You are awarded 80 hours of regular sick pay per year.** • Unused sick pay carries over to the following year up to a total of 640 hours. • You must work in the calendar year to receive and use the annual allowance of current sick pay. • You may qualify for additional sick pay hours at 10 and 20 years of service through low sick pay usage.**		Paid time off (PTO) applies. See page 135.
Holidays	**After completing six months of service and attaining regular status:*** • You're eligible for paid holidays. • Once you're eligible, you must be on paid status to earn fixed and floating holidays. Visit **mypgebenefits.com > Time Off and Accommodations** for details.	You're eligible for fixed holidays and floating holidays. Visit **mypgebenefits.com > Time Off and Accommodations** for details.	

***ESC-represented monthly-paid employees** are considered regular status upon date of hire for vacation and holidays. They do not have to wait six months before earning vacation and holidays.

**Amount is prorated for part-time employees.

PG&E Corporation Employees: paid time off (PTO)

PG&E Corporation employees accrue paid time off (PTO) in lieu of vacation and sick time:

- Your accrual rate for PTO is based on years of service.
- The maximum amount of PTO you may accrue (the cap) is twice the annual PTO maximum. This includes any unused PTO that is being carried over.
- You will not accrue additional PTO until the balance falls below the maximum of two times your annual PTO accrual rate.

Workplace accommodations

Do you need an accommodation due to a limitation or impairment—or other need PG&E may not be aware of—that could help you stay at work and perform the essential functions of your job?

To request an accommodation, email the Stay at Work/Return to Work team at **Accommodations-Req@pge.com**, or use the reasonable accommodation request form located at **mypgebenefits.com > Time Off and Accommodations > Workplace Accommodations and Internal Job Search Program**.

You can also talk to or email your supervisor or HR Representative about your request.

Voluntary Disability and Paid Family Leave Benefits

PG&E offers support when you need to be away from work to care for a family member, bond with a new child, recover from an illness or injury, or participate in a qualifying event as a result of a family member's military deployment to a foreign country.

PG&E's Voluntary Disability and Paid Family Leave Benefit Plan (the "Voluntary Plan") pays a wage replacement benefit if you're unable to work and experiencing a wage loss due to a non-work-related injury or health condition, including pregnancy, to bond with a new child, care for a family member, or due to a "qualifying military event (exigency)" arising out of the overseas military deployment of your family member.

The Voluntary Plan provides richer benefits and is offered in place of the California State Disability Insurance (SDI) and Paid Family Leave plan (the "State Plan"). The Voluntary Plan's richer benefits include:

- 60%* of your weekly salary replaced—with no weekly cap
- Streamlined application and pay process, including pay through PG&E's payroll cycle
- Available to all eligible employees—regardless of tenure, and at no additional cost (same cost as the State Plan)

The cost of contributions for the Voluntary Plan is the same as for the State Plan and actual amounts will show on your pay statement. You're required by law to contribute to one or the other. If you opt out of the Voluntary Plan, you'll be covered by the State Plan.

*55% benefit with no weekly cap (and no supplemental wage continuation benefits) for Hiring Hall, outage, temporary additional, probationary intermittent, interns and summer hire employees. At no time will an employee's weekly benefit amount under the Voluntary Plan be less than what the state would have otherwise provided.

The Voluntary Plan

Eligible California Utility employees are automatically enrolled in PG&E's Voluntary Disability and Paid Family Leave Benefit Plan (the "Voluntary Plan").

If you prefer to remain in the State Plan, you can opt out of the Voluntary Plan through your myPlans Connect account within 31 days of your hire date or within 31 days of becoming an eligible employee under the Voluntary Plan. Your State Plan coverage will be effective retroactive to your hire date or eligibility date.

After your first 31 days, you can opt in or out of the Voluntary Plan anytime during the year, with changes effective according to a special schedule available at **mypgebenefits.com > Time Off and Accommodations > Voluntary Disability and Paid Family Leave Benefit Plan**.

Anyone who opts out of the PG&E Voluntary Plan is required by state law to continue participating in the State Plan, which includes paying State Plan contributions and submitting claims for benefits through the state.

To view a comparison of State and Voluntary Plan benefits and a summary of Voluntary Plan coverage, go to **mypgebenefits.com > Time Off and Accommodations**.

WARNING: If you're a California Utility employee and you opt out of the Voluntary Plan, you won't receive PG&E-sponsored Supplemental Short-Term Disability or Paid Family Leave wage continuation benefits.

PG&E CORPORATION EMPLOYEES

PG&E Corporation employees in California are automatically covered by the California State Disability Insurance (SDI) and Paid Family Leave plan (the "State Plan"). You don't need to enroll for this coverage.

Time off	Union-represented employees	Management and A&T employees	PG&E Corporation employees
Paid Family Leave (PFL) **Monthly-paid employees:** You'll receive 100% weekly wage replacement based on your weekly wages, not monthly. This means you're likely to get more in longer months (March) and less in shorter months (February).***	**For California Utility employees covered under the PG&E Voluntary Plan:*** • You're eligible for benefits on the first day of your leave to care for an eligible family member or to bond with a new child, or due to a qualifying exigency arising out of the overseas military deployment of your family member. • You contribute to the Voluntary Plan via payroll deductions (same cost as State Plan). • Benefits for up to eight weeks per 12-month period. **Benefit amount:** • **60% weekly*** Voluntary Paid Family Leave (VPFL) benefits; federally taxable; no cap. • **Total weekly benefit of 100% pre-leave basic wage rate** through fully taxable PG&E Wage Continuation Supplement (60% VPFL + PG&E Wage Continuation Supplement).		**For eligible PG&E Corporation employees:** • You're eligible for benefits on the first day of your leave to care for an eligible family member or to bond with a new child, or due to a qualifying exigency arising out of the overseas military deployment of your family member. • You contribute to the State Plan via payroll deductions (California employees). • Benefits for up to eight weeks per 12-month period. **Benefit amount:** • 60% weekly California PFL benefits, up to the weekly maximum for eight weeks; federally taxable (California employees). • Total weekly benefit of 100% (fully taxable) pre-leave basic wage rate through fully taxable PG&E Wage Continuation Supplement (60% CA PFL + PG&E Wage Continuation Supplement).
PG&E Voluntary Plan Disability Insurance (VPDI) and Short-Term Disability (STD)** **Monthly-paid employees:** You'll receive 70% weekly wage replacement (grossed up) based on your weekly wages, not monthly. This means you're likely to get more in longer months (March) and less in shorter months (February).***	**For California Utility employees covered under the PG&E Voluntary Plan:*** • You contribute to the Voluntary Plan via payroll deductions (same cost as State Plan). • You become eligible for Voluntary Plan Disability Insurance (VPDI) benefits after seven consecutive calendar days of disability (waiting period may be waived, if hospitalized). • **60% weekly* VPDI benefits; non-taxable; no cap.** • Benefits for up to 52 weeks of disability. Receipt of VPDI is not an approval of leave. **Eligible Management, A&T and ESC-represented employees only:** • After Capped Sick Time ends, **weekly after-tax benefit of 70% of pre-disability basic wage rate** (60% VPDI + PG&E Wage Continuation Supplement); no cap. • STD benefits/leave for up to 52 weeks of disability.		**For eligible PG&E Corporation employees:** • You contribute to the State Plan via payroll deductions. • STD benefits are provided at no cost to you. • STD benefits start on the first day of hospitalization/accidental injury or after seven days of disability. • 60% weekly CA SDI benefits up to the state maximum (California employees). • Eligible employees get income protection of 66-2/3% of covered salary up to $2,564 per week, less offsets (such as CA SDI), for up to six months (180 days) of disability.

continued

Time off	Union-represented employees	Management and A&T employees	PG&E Corporation employees
Long-Term Disability (LTD)	**For eligible Management, A&T and Union-represented Utility employees:** • PG&E provides this benefit at no cost to you. • Eligible employees get a monthly benefit of 70% of covered salary, fully taxable and less any offsets, after 52 weeks of disability. • Benefits continue for two years. If you qualify for Social Security after two years, then benefits continue until normal retirement age if you still qualify for benefits under the LTD Plan. • Work Incentive Benefit up to five years. • No pension service credits will be earned while on LTD. You can resume earning pension service credits upon your return to work.		**For eligible PG&E Corporation employees:** • Participating employers provide this benefit at no cost to you. • Benefits start after six consecutive months of disability. • Eligible employees get a monthly benefit of 66–2/3% of covered salary up to $11,111 per month, less offsets.

*Interns, Hiring Hall, Temporary Additional, Outage and non-regular status intermittent employees are eligible for 55% Voluntary Paid Family Leave (VPFL) and Voluntary Plan Disability Insurance (VPDI) benefit and no supplemental benefits.
At no time will an employee's weekly benefit amount under the Voluntary Plan be less than what the state would have otherwise provided.

**If you're an eligible Management, A&T or ESC-represented employee working outside California, PG&E PFL and STD Wage Continuation supplements any state disability and paid family leave program for which you may be eligible.

***Your disability benefit may vary slightly based on the number of days in the month.

Other work/life benefits

Here are highlights of other PG&E benefits that can help you balance work and life.

Benefits	Union-represented employees	Management and A&T employees	PG&E Corporation employees
Tuition Refund	• You can enroll in approved courses that will help you perform your current duties and assume new duties in the future. • The amount of the tuition refund is based on your employment classification.*		
Adoption Reimbursement For when an employee adopts a child	• **After six months of service,** you'll be eligible for the Adoption Reimbursement program. • You can receive up to $2,000 for reimbursement of eligible expenses related to adopting children under age 18, including stepchildren.		
Employee Rates	• **After you have six months of service and attain regular status,** you'll be eligible for a 25% discount off PG&E-supplied electricity and gas as long as you live in the company's service territory. • The 25% discount applies to basic rates for one primary residence located in the company's service territory.	• **After six months of service,** you'll be eligible for a 25% discount off PG&E-supplied electricity and gas as long as you live in the company's service territory. • The 25% discount applies to basic rates for one primary residence located in the company's service territory.	N/A

*Employees represented by the IBEW, ESC or SEIU should refer to their Agreement for details.

Want more information?

Visit **mypgebenefits.com** for details about these programs.

Bright Horizons® Enhanced Family Support Program

You can access family care and education benefits through Bright Horizons (BH):

Family care	
Child care discounts	• Waived registration fee and preference on child care center waitlists at BH child care centers • Tuition discounts at BH partner centers, such as KinderCare
Free premium membership to Sittercity	• Free access to database of sitters for children, virtual sitting, caregivers, pet sitters, dog walkers, housekeeping services
Nanny placement discounts	• Personalized help finding full-time nannies through local agencies • Placement fee discount through College Nannies®, which provides background checks and training for the nannies they represent
Discounts on extracurricular programs and summer camp	• **Available in select school districts:** Before- and after-school care through Right At School • Summer day camp through Steve & Kate's Camp™
Free elder care resources	• Free online needs assessment, resource library, search tool for finding and evaluating in-home or facility-based care
Education support	
Tutoring and test prep discounts	• Virtual tutoring in 3,000+ subjects through Varsity Tutors • Personalized support for K-12 children through Sylvan Learning • Private tutoring, group tutoring and homework help through Revolution Prep
Enrichment program discounts	• Online robot-building classes for STEAM learning (science, technology, engineering, arts, math) through Brooklyn Robot Foundry • Online game-focused programs teaching coding and STEM learning (science, technology, engineering, math) through Code Ninjas
Adult education discounts	• Access to EdAssist Solutions' Education Coaches and College Finance Coaches • Discounts at hundreds of colleges and universities nationwide

Visit **clients.brighthorizons.com/pge** for more information about the programs available to you.

Paid Sick Leave Designee

If you're a Management or A&T employee who works in San Francisco, Emeryville, Oakland or Berkeley, you can use up to 72 hours per calendar year of incidental sick time to care for a family member.

If you don't have a spouse or registered domestic partner, you can use this time to care for a "designated person" that you have registered with PG&E.

Go to **mypgebenefits.com** to download the form to select your Paid Sick Leave Designee. You'll need to send your completed form to your supervisor and the PG&E HR Help Line.

Contact the PG&E HR Help Line to:

- Add a designee
- Drop a designee
- Change information about a designee

QUESTIONS?

Contact the PG&E HR Help Line:

Submit an AskHR Request by visiting **http://AskHR**

Call **415-973-4357**

Representatives are available Monday–Friday, 8 a.m.–4 p.m. Pacific time

Retirement benefits

PG&E's retirement benefits can help you build financial security for the future.

401(k): Retirement Savings Plan

The Retirement Savings Plan (RSP) is a 401(k) plan that gives you a way to save for retirement through your own before-tax or after-tax contributions plus company matching contributions.

How the 401(k) plan works

The participation and contribution rules for PG&E's 401(k) plan—the Retirement Savings Plan (RSP)—are different depending on which pension formula you have.

Company matching contributions

Company matching contributions will be made in cash and invested based on your investment elections on file with Fidelity.

Each pay period, you need to contribute the full percentage of your pay that's eligible for company matching contributions in order to get the maximum match.

Hired in 2013 or later—or have the cash balance pension formula

Were you hired on or after January 1, 2013—or did you elect the cash balance pension formula in 2013? You'll be automatically enrolled in the 401(k) plan at an 8% contribution level when you're first eligible and every January 1 if you stop contributing or reduce your contributions below 8% during the year.

You can change, stop or re-start your contributions at any time. In addition, there are different rules for contributions based on your employment classification:

Union-represented employees

Your contributions

As soon as you're hired, you can enroll and start making contributions.

30 days after you're hired—if you haven't already enrolled, you'll be automatically enrolled at an 8% contribution level.

You can contribute up to 20% of your base salary—up to the annual dollar limit set by the IRS.

Company contributions

After one year of service, PG&E will match $0.75 per $1 of your before-tax and/or after-tax contributions that do not exceed 8% of your basic weekly pay.

Management, A&T and PG&E Corporation employees

Your contributions

As soon as you're hired, you can enroll and start making contributions.

30 days after you're hired—if you haven't already enrolled, you'll be automatically enrolled at an 8% contribution level.

You can contribute up to 50% of your base salary—up to the annual dollar limit set by the IRS.

Company contributions

PG&E will match $0.75 per $1 of your before-tax and/or after-tax contributions that do not exceed 8% of your base pay.

Every January 1—if you stopped contributing—or if you're contributing less than 8%—you'll be automatically enrolled at an 8% contribution level.

Employees can contribute up to the annual IRS limit in before-tax contributions.

Employees age 50 or older can contribute more in before-tax "catch up" contributions—up to the annual IRS limit.

How matching contributions work: Hired in 2013 or later—or have the cash balance pension formula

Here's how company matching contributions are calculated.

HIRED IN 2013 OR LATER OR YOU ELECTED THE CASH BALANCE PENSION FORMULA:

Union-represented employees		
You become eligible for the company match after you have **one year of service.*** After that, PG&E will match $0.75 per $1 you contribute up to 8% of your eligible pay.	1%	0.75%
	2%	1.50%
	3%	2.25%
	4%	3.00%
	5%	3.75%
	6%	4.50%
	7%	5.25%
	8%	6.00%

Management, A&T and PG&E Corporation employees		
You become eligible for the company match as soon as you start contributing to the plan. PG&E will match $0.75 per $1 you contribute up to 8% of your eligible pay.	1%	0.75%
	2%	1.50%
	3%	2.25%
	4%	3.00%
	5%	3.75%
	6%	4.50%
	7%	5.25%
	8%	6.00%

*See page 148 for details about years of service.

Hired before 2013 and have the final pay or final average pay pension formula

Were you hired before 2013—and are you continuing to participate in the final pay or final average pay pension formula?

You'll need to make an election if you want to contribute to the 401(k) plan. You won't be automatically enrolled.

How much you and the company can contribute to your 401(k) account depends on your employment classification:

Union-represented employees

Your contributions

You can contribute up to 20% of your base salary—up to the annual dollar limit set by the IRS.

Company contributions

When you have 3+ years of service, PG&E will match $0.60 per $1 of your before-tax and/or after-tax contributions that do not exceed **6% of your basic weekly pay**.

Management, A&T and PG&E Corporation employees

Your contributions

You can contribute up to 50% of your base salary—up to the annual dollar limit set by the IRS.

Company contributions

As soon as you begin contributing to the 401(k) plan, PG&E will match $0.75 per $1 of your before-tax and/or after-tax contributions that do not exceed **6% of your base pay**.

How matching contributions work: Hired before 2013

Here's how company matching contributions are calculated.

HIRED BEFORE 2013:

Union-represented employees		
You become eligible for the company match after you have 12 months of service. **1–3 years of service:** PG&E will match $0.60 per $1 you contribute up to 3% of your eligible pay.	1%	0.60%
	2%	1.20%
	3%	2.80%
3+ years of service: PG&E will match $0.60 per $1 you contribute up to 6% of your eligible pay.	1%	0.60%
	2%	1.20%
	3%	1.80%
	4%	2.40%
	5%	3.00%
	6%	3.60%
Management, A&T and PG&E Corporation employees		
You become eligible for the company match as soon as you start contributing to the plan. PG&E will match $0.75 per $1 you contribute up to 6% of your eligible pay.	1%	0.75%
	2%	1.50%
	3%	2.25%
	4%	3.00%
	5%	3.75%
	6%	4.50%

Years of service for Union-represented employees

A year of service is defined as the completion of 12 months of employment with PG&E. If you terminated your employment with PG&E and are later rehired, your past service may be considered when determining your years of service.

If you worked more than 12 months before your employment ended or you're rehired within 12 months of your termination date, you'll receive credit for your past service.

Retirement Savings Plan (RSP) features

These features apply for all eligible employees:

- **You can change, stop or re-start** your contributions anytime.
- **You're immediately 100% vested** in the full RSP account balance.
- You have a choice of accessing **free online investment advice or fee-based professional management services** at a reduced corporate rate through Edelman Financial Engines®.
- **You can roll over balances** from another employer's qualified retirement plan or IRA into the RSP.
- **You can choose from a wide variety of investment funds**, and in general, you can change your investments anytime.
- **Benefits under the RSP fluctuate** with investment returns.

Visit **mypgebenefits.com > Financial Health > 401(k) Retirement Savings Plan** or log in to your Fidelity NetBenefits account at **401k.com** for details about the RSP, including IRS limits.

GETTING STARTED

Fidelity Investments® administers the RSP. You can set up your personalized online account through Fidelity NetBenefits® at 401k.com for 24/7 access.

Access your RSP account anywhere, anytime, with the NetBenefits mobile app.

Elect your beneficiary

Log in to your NetBenefits account at 401k.com to elect your 401(k) beneficiary.

This is a separate election from your life insurance and pension beneficiary elections. Your beneficiary elections for one benefit won't carry over to another benefit.

Maximize your retirement savings with after-tax contributions

The RSP offers an after-tax contribution option to help you maximize your retirement savings. If you reach the annual IRS before-tax 401(k) contribution limit, you can continue to save for retirement by making after-tax contributions.

If you're hitting the annual IRS before-tax 401(k) contribution limit before the end of the year, you may miss out on the company match. Company matching contributions are only made when you make before-or after-tax contributions to the RSP.

To ensure you receive the company match every month, consider reducing your contribution percentage so your contributions are evenly allocated over the entire year—or update your after-tax contributions.

After-tax contributions receive the company match up to plan limits. Your after-tax contributions are deducted from your paycheck after all other deductions have been taken (including applicable taxes). After-tax contributions allow you to invest more money with the potential for tax-deferred growth.

The after-tax contribution option allows you to:

Elect a **spillover option**, which converts your selected before-tax contribution percentage to an after-tax contribution once you reach the IRS annual before-tax contribution limit

OR

Select personalized before- and after-tax contribution percentages from each paycheck (for example, 10% before-tax and 5% after-tax contributions from each paycheck)

Roth IRA

Once you've made after-tax contributions to the RSP, you can leave these contributions in the plan—or, if eligible, you can roll some or all of your after-tax contributions into a Roth IRA.

The tax rules related to rolling over after-tax contributions are complicated, so be sure to consult with a tax advisor before setting up a Roth IRA or transferring any of your RSP after-tax contributions to a Roth IRA.

Log in to Fidelity NetBenefits at 401k.com to:

- Change your before- or after-tax contribution percentages
- Make a spillover election

For information about how to set up a Roth IRA, you can contact Fidelity or another eligible financial institution.

To reach Fidelity, call 1-877-743-4015 Monday–Friday except New York Stock Exchange holidays, 5:30 a.m.–9 p.m. Pacific time.

Pension: PG&E Retirement Plan

The PG&E Retirement Plan is a defined benefit plan—meaning the benefit you receive is defined by a formula.

The plan has three formulas based on when you were hired and your employment classification.

Hired in 2013 or later

You have the **cash balance 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. See page 154 for details.

Union-represented employee hired before 2013

You have the **final pay formula** if you were a Union-represented employee hired before 2013—or if you chose to continue participating in the final pay formula during a special, one-time election period in 2013. See page 157 for details.

Management or A&T employee hired before 2013

You have the **final average pay formula** if you were a Management or A&T employee hired before 2013—or if you chose to continue participating in the final average pay formula during a special, one-time election period in 2013. See page 157 for details.

Confirm your pre-retirement pension beneficiaries today

You'll need to elect or update your pre-retirement pension beneficiaries in case something happens to you before you retire. Don't assume a default election will protect your family

EXAMPLE:

If you've named your spouse as your primary beneficiary and you later divorce, never remarry, and forget to update your primary beneficiary, your former spouse could still receive the benefit.

Even if you've named contingent beneficiaries, such as children, they would not receive any benefit. You would need to update your beneficiary designation to remove your former spouse as the primary beneficiary.

Contingent beneficiaries

You can allocate different percentages to multiple contingent beneficiaries by logging in to your PG&E PensionConnect account or by calling the PG&E Pension Service Center.

- If you die before your pension starts, your pre-retirement primary pension beneficiary will get a benefit.
- If both you and your pre-retirement primary pension beneficiary die before your pension starts, your contingent beneficiaries will get a benefit.

Your beneficiary elections for pre-retirement pension, 401(k) and Life and Accident Insurance are all separate elections. Your beneficiary elections for one benefit won't carry over to another benefit.

The contingent beneficiaries you elect (typically your children or other family members) will get your pre-retirement pension benefit if both you and your pre-retirement primary pension beneficiary pass away **before you retire and start your pension**.

If you have no contingent beneficiaries on file, your loved ones will end up with nothing if both you and your pre-retirement primary pension beneficiary pass away before you retire and start your pension.

EXAMPLE:

This could happen if your pre-retirement primary pension beneficiary passes away and **you simply forget** to update your beneficiary—and you later pass away without electing contingent beneficiaries.

NOTE: Your pre-retirement pension beneficiary elections won't carry over to your postretirement pension elections. You'll be able to choose a pension beneficiary as part of the pension election process when you're ready to start your pension benefit.

Elect or update your pre-retirement pension beneficiaries today. It's easy:

1. Log in to your PG&E PensionConnect account:
   Using a PG&E computer within the network: Go to *PG&E@Work for Me* and click **My Retirement > PG&E PensionConnect**. You'll be automatically logged in.
   OR
   From a personal device: Log in at **myPensionConnect.com**. If logging in from a personal device for the first time, you'll need to create a username and password.
2. Click on the **Your Beneficiaries** homepage tile. On the designation page, name your primary and contingent beneficiaries and save your elections.

Need help? Call PG&E's Pension Service Center at **1-800-700-0057** from 7:30 a.m. to 5 p.m. Pacific time, Monday through Friday.

Cash balance formula

The cash balance formula lets your pension benefit accumulate for each year you work in a pension-eligible position—not just at the end of your employment.

You accrue annual pay credits based on full years of age and full years of credited service—plus, your account is credited with interest on the last day of each calendar quarter.

Here's how it works:

1. **The plan provides annual "pay credits" of 5%–10% of your pay** (based on your age and service at the end of each year), plus quarterly interest credits based on 30-year Treasury rates.

2. **You build an account balance** (much like a savings account) based on your accumulated annual pay credits plus quarterly interest credits. While your benefit varies with interest credits, your account balance isn't dependent on the investment returns of the pension plan assets.

3. **You become fully vested after three years of service or age 55.** Your vested account balance is portable when your employment ends. You can take your vested account balance as:
   - A monthly payment for your lifetime only or for the combined lifetime of you and your spouse or beneficiary—or
   - A single lump-sum payment that you can roll over to an IRA or other qualified employer plan.

Were you rehired by PG&E? Past service will count toward vesting and points.

Cash balance formula: Annual pay credits

Annual pay credits are based on a point system of full years of age and full years of credited service as of December 31 each year:

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

EXAMPLE:

55 years old + 21 years of service = **76 points** (55 + 21)

This person would get an annual pay credit of 9% of pay.

Cash balance formula: Quarterly interest credits

Quarterly interest credits* are credited to your account on the last day of each calendar quarter.

The quarterly interest rate is based on the average 30-year Treasury rate for the preceding quarter, divided by four to determine the quarterly equivalent of the average annual yield.

EXAMPLE:

April through June quarterly rate = an average of the monthly rates for January through March—divided by four.

*For any calendar quarter, the quarterly interest rate can't be less than 0.4875%. This is the quarterly equivalent of the minimum annual interest rate that PG&E guarantees in the Retirement Plan regardless of the Treasury rate.

Example:
How your cash balance pension account can grow

Let's assume Sam is age 45 with 10 years of service and currently earns $90,000 a year. Sam's 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	YEAR 2	YEAR 3	YEAR 4	YEAR 5
Beginning Balance	$0.00	$6,300.00	$12,980.13	$20,057.61	$28,533.77
Points (Age + 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.

Final pay and final average pay formulas

If you were hired before 2013

Final pay formula: For Union-represented employees hired before 2013

You accrue a pension benefit based primarily on your **final pay rate**, age and years of service. You become fully vested in the final pay formula after five years of service or at age 55.

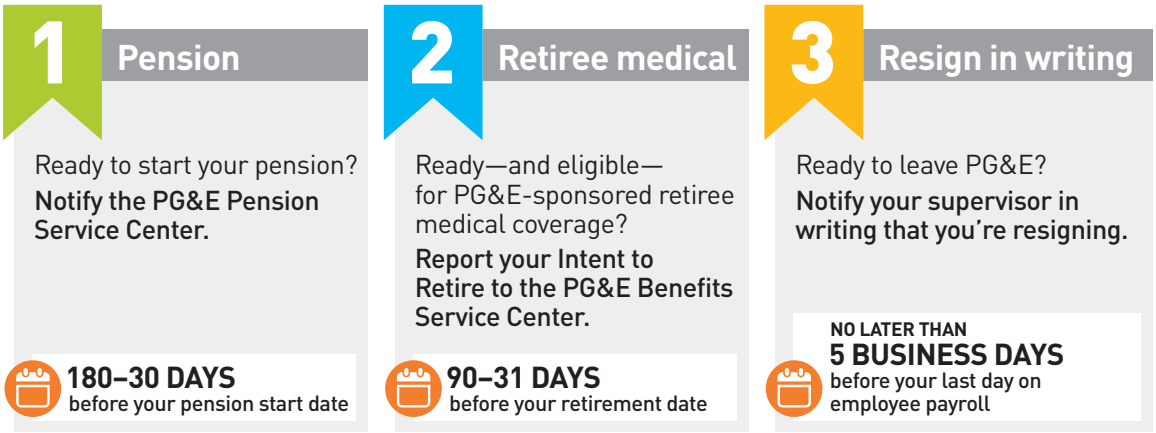
Final average pay formula: For Management or A&T employees hired before 2013

You accrue a pension benefit based on your **final 36 months of pay**, age and years of service. You become fully vested in the final average pay formula after five years of service or at age 55.

If you have either of these formulas, you can calculate your estimated pension benefit with the PG&E Pension Estimator, available when you log in to your PG&E PensionConnect account.

How to retire

There are three big steps you'll need to take when you're ready to retire.



MORE INFORMATION

You can find details about retirement benefits and how to retire at **mypgebenefits.com > Financial Health > Retirement Planning**.

Retiree medical coverage

PG&E offers retiree medical coverage for you and your eligible dependents when you retire at age 55 or older with at least 10 years of service.

When you're ready to retire, you'll need to report your Intent to Retire to the PG&E Benefits Service Center 90 to 31 days before your retirement date. If you're eligible for retiree medical coverage, you'll receive a retiree medical enrollment kit in the mail.

Retiree Medical Savings Account

In addition to retiree medical coverage, you and your spouse or registered domestic partner can each receive a company-paid **Retiree Medical Savings Account (RMSA)** when you retire. You can use the RMSA to help pay for your PG&E-sponsored retiree medical premiums. The RMSA is notional, which means it has no cash value. Your starting RMSA balances are based on your date of hire, age and years of service.

For more information about PG&E-sponsored retiree medical coverage, visit **mypgebenefits.com > Physical Health > Retiree Medical**.

Postretirement life insurance

When you retire after age 55, PG&E provides company-paid postretirement life insurance at no cost to you.

Union-represented employees are eligible for coverage of $8,000.

Management, A&T and PG&E Corporation employees are eligible for coverage of $8,000 or up to $50,000 based on years of service and employment history:

Management, A&T and PG&E Corporation employees	Coverage
Fewer than 15 years of credited service*	$8,000
Hired or promoted into a Management position **before January 1, 1986**—with 15+ years of credited service*	Last 12 months of base salary **OR** Optional $50,000 to avoid imputed income taxes on amounts over $50,000
Hired or promoted into a Management position **on or after January 1, 1986**—with 15+ years of credited service*	**Whichever is less:** $50,000 **OR** Last 12 months of base salary
A&T employees with 15+ years of credited service	$50,000

***Were you hired directly by PG&E Corporation (not the utility) before April 1, 2007?** Your service will be based on your original hire date, not your credited service date under the Retirement Plan.

Are you an officer or director? Contact the PG&E Pension Service Center to find out if you have an election on file for a lump-sum payment of life insurance benefits: **1-800-700-0057**.

For more details, visit **mypgebenefits.com > Financial Health > Postretirement Life Insurance**.

Contact information

Start here

Have questions about your benefits? Need help enrolling?

CALL

Call the PG&E Benefits Service Center at **1-866-271-8144** Monday–Friday, 7:30 a.m.–5 p.m. Pacific time.

EMAIL

Log in* to your **myPlans Connect account** and send a secure message to a service representative.

You'll get a reply within three business days.

CHAT

Log in* to your **myPlans Connect account** and chat online with a service representative Monday–Friday, 7:30 a.m.–5 p.m. Pacific time.

You can also chat 24/7 with **Ava**, the digital assistant.

*Go to **mypgebenefits.com** and click **Learn More** under **Manage Your Benefits**.

Have a question? Chat with Ava.

Log in to **myPlans Connect** for 24/7 access to Ava, PG&E's artificial intelligence (AI) app.

You can ask questions and Ava will respond or give you directions on where to find more information.

LOG IN SECURELY

myPlans Connect uses multi-factor authentication to keep your information secure when you log in outside the network. Each time you log in outside of *PG&E@Work for Me*, you'll need your:

- User ID
- Password
- Temporary numeric code that will be sent to your email address or mobile phone number (you'll need to receive a new code each time you log in)

Be sure to use a unique, long password—at least eight characters—to help keep your account secure.

Need help? Call the PG&E Benefits Service Center: **1-866-271-8144**.

Health and wellness

I NEED TO:

- Sign up for a health screening or tobacco test

Health and Wellness	Contact
Quest Diagnostics Representatives are available • Monday–Friday, 5 a.m.–6 p.m. Pacific time • Saturday, 5:30 a.m.–2 p.m. Pacific time	**1-866-271-8144, option 1** and then **option 3** Email **wellness@questdiagnostics.com** Schedule your appointment at **My.QuestForHealth.com** Sign in or register using the registration key: **PGE2024** Then follow the prompts

- Set up my account in the Virgin Pulse portal (you must do this before you can access any of the Virgin Pulse programs and activities)
- Enroll in the tobacco cessation program
- Sign up for health coaching
- Access resources like Journeys, nutrition and sleep guides and participate in challenges

Virgin Pulse Representatives are available Monday–Friday, 5 a.m.–6 p.m. Pacific time	**You must first register with Virgin Pulse:** On the Virgin Pulse app, search and select **PG&E** **OR** Visit **join.virginpulse.com/pgewellness** Schedule your phone appointment at: **1-866-271-8144, option 1** and then **option 4**

Medical coverage

I NEED TO:

- Talk to my medical plan's Member Services about my benefits
- Preauthorize care
- Find out if my provider belongs to the plan's network
- Get help filing a claim
- Dispute a claim
- Get a medical plan ID card

Medical	Contact	Group Number
Anthem Blue Cross Health Account Plan (HAP) Representatives are available Monday–Friday, 7 a.m.–8 p.m. Pacific time	**1-800-964-0530** **anthem.com/ca/pge** **Sydney Health app**	170157
Kaiser Permanente Health Account Plan (HAP) Representatives are available: • Monday–Friday, 7 a.m.–7 p.m. Pacific time • Saturday and Sunday, 7 a.m.–3 p.m. Pacific time	NORTH: **1-800-663-1771** SOUTH: **1-800-533-1833** **kp.org** **Kaiser Permanente app**	North: 603702 South: 231142
FOR CHIROPRACTIC AND ACUPUNCTURE: **American Specialty Health Network (ASH)** Representatives are available: • Monday–Friday, 4 a.m.–7 p.m. Pacific time • Saturday, 7 a.m.–5 p.m. Pacific time Closed on holidays	**1-800-678-9133** **ashcompanies.com**	N/A

Express Scripts prescription drug coverage

I NEED TO:

- Find out if my prescription drug is covered
- Get help filing a claim
- Dispute a claim
- Get an Express Scripts ID card

Prescription Drug	Contact	Group Number
Prescription Drug Plan **Administered by Express Scripts** **For Anthem HAP members** **Representatives are available 24/7; closed Thanksgiving and Christmas**	**1-800-718-6590** **express-scripts.com** Express Scripts app	**PGE0000**

Prescription drug benefits are included in the Kaiser Permanente HAP

Mental health and substance use disorder coverage

I NEED TO:

- Find out if my treatment will be covered
- Preauthorize care
- Get help filing a claim
- Dispute a claim

Mental Health and Substance Use Disorder	Contact
Mental Health and Substance Use Disorder (MHSUD) Program **Administered by Carelon Behavioral Health** **For Anthem and Kaiser Permanente members** **Representatives are available 24/7**	**1-888-445-4436** **carelonbehavioralhealth.com**

Dental coverage

I NEED TO:

- Find out if my dentist is a Delta Dental PPO or Premier dentist
- Get a pre-treatment estimate
- Get help filing a claim
- Dispute a claim

Dental	Contact	Group Number
Dental Plan **Administered by Delta Dental** **Representatives are available** **Monday–Friday, 5 a.m.–8 p.m. Pacific time**	**1-888-217-5323** **deltadentalins.com/pg&e** Delta Dental Mobile app	Utility Dental Plan: **1515-0132** Corporation Dental Plan: **1515-0232** IBEW- and SEIU-represented employees: **1515-0101** ESC-represented employees: **1515-0106**

Vision coverage

I NEED TO:

- Find out if my eye doctor is a VSP provider
- Get a cost estimate for vision services and products—such as exams, lenses, frames and Lasik surgery
- Find out about discounts on frames and retinal screenings
- Get help filing a claim
- Dispute a claim

Vision	Contact	Group Number
Vision Plan **Administered by Vision Service Plan (VSP)** **Representatives are available:** • **Monday–Saturday, 6 a.m.–5 p.m. Pacific time** • **Sunday, closed**	**1-800-877-7195** **vsp.com** VSP Vision Care On the Go app	Management and A&T employees: **00401601–Div 1109** Union-represented employees: **00401601–Div 1115**

Health Account

I NEED TO:

Get help filing a claim or processing a reimbursement through the Health Account

Anthem Health Account

Administered by Optum Financial

Representatives are available
Monday–Friday, 5 a.m.–5 p.m. Pacific time

1-866-271-8144 to request a claim form

Log in to your myPlans Connect account or go to **OptumFinancial.com**

Optum Financial free mobile app

Kaiser Permanente Health Account

Administered by Kaiser Permanente

Representatives are available
Monday–Friday, 5 a.m.–7 p.m. Pacific time

1-877-750-3399, option 1 and then **option 2**

kp.org/healthexpense

Kaiser Permanente HRA/HSA/FSA Balance Tracker app

Flexible Spending Accounts (FSAs)

I NEED TO:

Get help filing a claim or processing a reimbursement through the Health Care or Dependent Care Flexible Spending Account (FSA)

Enrolled in the Anthem Health Account Plan (HAP)? Waive medical coverage + enroll in an FSA for the current year?

Administered by Optum Financial

Representatives are available
Monday–Friday, 5 a.m.–5 p.m. Pacific time

1-866-271-8144 to request a claim form

Log in to **OptumFinancial.com** to file claims

Optum Financial free mobile app

Enrolled in the Kaiser Permanente Health Account Plan (HAP)?

Kaiser Permanente

Representatives are available
Monday–Friday, 5 a.m.–7 p.m. Pacific time

1-866-271-8144, option 1 and then **option 2**

kp.org/healthexpense

Kaiser Permanente HRA/HSA/FSA Balance Tracker app

Other health and wellness benefits

I NEED TO:

Talk with a licensed EAP counselor and get help with day-to-day stresses and concerns

Employee Assistance Program (EAP)
Administered by Carelon Behavioral Health

Onsite counselors
Find counselor contact information and hours:
mypgebenefits.com > Mental Health and Family Support > Employee Assistance Program (EAP)

Online appointment scheduler
Schedule video, phone, text, chat or in-person visits directly online:
pge.mybeaconwellbeing.com

24/7 hotline
1-888-445-4436

Find out about COBRA coverage and costs

COBRA
Administered by Optum Financial
Representatives are available
Monday–Friday, 5 a.m.–5 p.m. Pacific time
1-866-271-8144, option 3
OptumFinancial.com

Open a Leave or Disability Claim

Sedgwick, CMS
Representatives are available
Monday–Friday, 5 a.m.–5 p.m. Pacific time
1-855-732-8217
claimlookup.com/pge

Pay restitution for covering ineligible dependents

Direct billing
Administered by Optum Financial
Representatives are available
Monday–Friday, 5 a.m.–5 p.m. Pacific time
1-866-271-8144, option 3
OptumFinancial.com

Report work-related discomfort or injury

24/7 Nurse Care Line
1-888-449-7787
Or submit via the NCL app

Find out how to schedule a virtual doctor, psychiatry or counseling appointment

Anthem LiveHealth Online telehealth
1-888-548-3432
Email **customersupport@livehealthonline.com**

Kaiser Permanente Video Visits
kp.org/mydoctor/videovisits

EAP or Carelon Behavioral Health
1-888-445-4436
pge.mybeaconwellbeing.com

Anthem members: Learn about Anthem's cancer case management program

Anthem cancer case management program
Representatives are available
Monday–Friday, 9 a.m.–8 p.m. and
Saturday, 9 a.m.–4:30 p.m. Pacific time
1-888-613-1130

Get confidential help managing health concerns

KnovaSolutions
Representatives are available
Monday–Friday, 5 a.m.–5 p.m. Pacific time
1-800-355-0885
ContactKnovaSolutions@workpartners.com

continued

Other health and wellness benefits

continued from previous page

I NEED TO:

Find out about the PG&E Health Centers

Patient portal: mypremisehealth.com
All hours are Pacific time.

Oakland: Premise Health Wellness Center
2201 Broadway Blvd., Suite 101, Oakland, CA 94612
(two blocks from Lakeside Headquarters)
Clinic hours: 7:30 a.m.–4:30 p.m. (closed for lunch 12:30–1:30 p.m.)
Lab hours: 8 a.m.–12:30 p.m.
510-473-8700

San Carlos: PG&E Health Center
275 Industrial Way, Room 103-104,
San Carlos, CA 94070
Clinic hours: 7 a.m.–4 p.m. (closed for lunch 12–1 p.m.)
Lab hours: 8 a.m.–12 noon
650-598-7227

Fresno: PG&E Health Center
3580 E. California Avenue, Bldg B, Room 01-1502,
Fresno, CA 93702
Clinic hours: 7 a.m.–4 p.m. (closed for lunch 12–1 p.m.)
Lab hours: 8 a.m.–12 noon
559-263-7555

Get free sports medicine and ergonomic help at work

Industrial Athlete and Ergonomics
Field coworkers: Email
industrialathlete@pge.com
Office coworkers: Email
officeergonomics@pge.com

Talk to someone who is in recovery from his or her own substance use disorder or that of a loved one

Peer Volunteer Program
Peer Volunteers are available 24/7
Call any Peer Volunteer listed at
mypgebenefits.com > Mental Health and Family Support > Peer Volunteer Program (PVP)
or
call the EAP at **1-888-445-4436**
and ask to have a Peer Volunteer call you back

Retirement benefits

I NEED TO:

Get help with my 401(k)

Fidelity
Representatives are available
Monday–Friday except New York Stock Exchange holidays, 5:30 a.m.–9 p.m. Pacific time

Log in to your NetBenefits account at **401k.com**
1-877-PGE-401k (1-877-743-4015)
NetBenefits app

Get help with my retirement questions

PG&E Pension Service Center
Representatives are available
Monday–Friday except holidays,
7:30 a.m.–5 p.m. Pacific time
1-800-700-0057

Beneficiary updates

I NEED TO:

Elect or update my beneficiary for life and accident insurance

Log in to your myPlans Connect account
mypgebenefits.com

OR

Call the PG&E Benefits Service Center
1-866-271-8144, option 1 and then **option 5**

Elect or update my beneficiary for the 401(k)—PG&E Retirement Savings Plan

Log in to your NetBenefits account
401k.com
NetBenefits app

Elect or update my pre-retirement beneficiaries for the pension—PG&E Retirement Plan

Log in to your PG&E PensionConnect account at
myPensionConnect.com

OR

Call the PG&E Pension Service Center
1-800-700-0057

Address updates

I NEED TO:

Update my address or phone number

Log in from work ***PG&E@Work for Me*** **> My Personal Information**

OR

Call the PG&E HR Help Line
415-973-4357
Submit a ticket through **AskHR**

Other work/life benefits

I NEED TO:

Enroll in the Commuter Transit Program, change or cancel my order or file a claim

Commuter Transit Program
Administered by Optum Financial
Representatives are available
Monday–Friday, 5 a.m.–5 p.m. Pacific time
1-866-271-8144, option 1 and then **option 5**
Log in to your Optum Financial account through myPlans Connect or **OptumFinancial.com**

Change my Paid Sick Leave Designee

PG&E HR Help Line
Representatives are available
Monday–Friday, 8 a.m.–4 p.m. Pacific time
415-973-4357
http://askhr

Request medical assistance or get help with lost items while traveling on an international business trip

International business travel assistance
Administered by Aetna WorldTraveler
If you're eligible for this service, you'll receive an Aetna WorldTraveler card with contact information and details about how to register.

Find locations of Lactation Rooms at Work

Lactation Rooms at Work
mypgebenefits.com > Work/Life Benefits > Mental Health and Family Support > Lactation Rooms

Learn about work accommodations for special needs

Stay at Work, Return to Work, Absence and Accommodations
Email **accommodations-req.pge.com**

More details

I NEED TO:

- Read details about my benefits

Summary of Benefits Handbook
Representatives are available
Monday–Friday, 7:30 a.m.–5 p.m. Pacific time
1-866-271-8144, option 1 and then **option 5,** to request a free copy
mypgebenefits.com > Resources > Summary of Benefits Handbooks

- Access my legal notices

mypgebenefits.com > Resources > Legal Notices

- Get information and publications from the Internal Revenue Service (IRS)

IRS Publications
1-800-829-3676
www.irs.gov

- Learn what my Power of Attorney (POA) agent needs to know and do

Power of Attorney Guide
mypgebenefits.com > Mental Health and Family Support > Power of Attorney

Safety

I NEED TO:

- Report a motor vehicle incident (MVI)

Motor Vehicle Incident
pge.sharepoint.com/sites/MVS

- Report a near hit

Share Near Hit
1-866-268-6682

Form 1095

I NEED TO:

- **AFTER JANUARY**—Get a copy of my Form 1095 to verify that I had minimum essential health coverage for the prior year

Anthem Health Account Plan (HAP)
Kaiser Permanente Health Account Plan (HAP)
PG&E Benefits Service Center
1-866-271-8144

Other financial services

I NEED TO:

Make life insurance changes

Life insurance

Insured by MetLife; Group Number 74300

Representatives are available
Monday–Friday, 7:30 a.m.–5 p.m. Pacific time

1-866-271-8144, option 1 and then **option 5**

Don't call MetLife. Instead, log in to your myPlans Connect account. MetLife is not the administrator until after you file a claim.

mypgebenefits.com

Get help preparing a will or managing the probate process for my estate

Will preparation and estate resolution services

Administered by MetLife Legal Plans;
Group Number 74300

Representatives are available
Monday–Friday, 5 a.m.–4 p.m. Pacific time

1-800-821-6400

Trusts and estate planning

No-cost consultation and discounted services are available through the Employee Assistance Program (EAP)

1-888-445-4436

pge.mybeaconwellbeing.com/legal

Get help planning or paying for a funeral

Funeral discount and planning services

Administered by MetLife Advantages and Dignity Memorial

Dignity Memorial representatives are available
24/7, 365 days/year

1-866-853-0954

finalwishesplanning.com

Work-related concerns

I NEED TO:

Ask about time off

PG&E Leave Team

Email **pgeleaveteam@pge.com**

Ask about my job classification or title

PG&E HR Help Line

Representatives are available
Monday–Friday, 8 a.m.–4 p.m. Pacific time

415-973-4357

http://askhr

Access my work-related information

PG&E@Work for Me

https://myportal.pge.com (PG&E intranet)

Get help with computer and phone issues, including remote access

PG&E Technology Service Center (TSC)

Representatives are available
24 hours a day, 7 days a week

Utility employees: **415-973-9000**

PG&E Corporation employees: **415-267-7025**

Find out about my pay, benefits, time off and other HR-related questions

PG&E@Work for Me **> Human Resources**

pge.sharepoint.com/sites/HumanResourcesHub
(PG&E intranet)

Confirm your beneficiaries today

Have you had a change in life status? Did you get married or divorced? Have a baby or adopt a child? Be sure to elect or update your pre-retirement pension, 401(k) and Life and Accident insurance beneficiaries.

Pension—PG&E Retirement Plan

Log in to your PG&E PensionConnect account.

Using a PG&E computer within the network: Go to ***PG&E@Work for Me*** **> My Retirement > PG&E PensionConnect**

From a personal device: Log in at **myPensionConnect.com**

Need help? Call the PG&E Pension Service Center: **1-800-700-0057**

401(k)—PG&E Retirement Savings Plan

Log in to your NetBenefits account at **401k.com**

Life and accident insurance

Log in to your myPlans Connect account: **mypgebenefits.com**

OR

Call the PG&E Benefits Service Center: **1-866-271-8144**

These are all separate elections. Your beneficiary elections for one benefit won't carry over to another benefit.