ATTACHMENT B

ACTIVE MEDICAL, DENTAL, VISION AGREEMENT AND RETIREE MEDICAL

ACTIVE MEDICAL

The Company and Union agree to modify the current medical plan in the following ways:

1. Effective January 1, 2027, introduce a High-Deductible Health Plan (HDHP)[1] with Health Saving Account (HSA) option with both Anthem and Kaiser. The HDHP option will have a 7.5% medical plan premium for full-time and part-time employees.

    a. Provide company funded annual contributions to an HSA for all enrolled members who meet HSA eligibility requirements.
        i. $800 HSA contribution for single coverage
        ii. $1,600 HSA contribution for family coverage
        iii. Members will also be eligible to make their own contributions to their HSA account
        iv. Members may use HSA funds for any IRS eligible expenses.

    c. Implement a Limited Purpose Health Reimbursement Account (LPHRA) for those enrolled in the HDHP
        i. Provide company funded $500 annual contributions to LPHRA for all HDHP enrolled employees.
        ii. Under IRS regulations, the LPHRA is limited to dental and vision expenses until the deductible is met. After the deductible is met, it may be used for all eligible medical expenses.
        iii. Any accrued balances in an existing company funded Health Reimbursement Account (HRA) will be transferred to LPHRA.

    d. Annual medical plan deductible for in-network services is $1,700 (single) or $3,400 (family).

    e. Annual medical plan deductible for out-of-network services is $3,400 (single) or $6,800 (family).

    f. Annual medical plan out-of-pocket maximum for in-network is $3,400 (single) or $6,800 (family).

    g. Annual medical plan out-of-pocket maximum for out-of-network is $6,800 (single) or $13,600 (family).

    h. Once the deductible has been met, coinsurance will be 20% for in-network services and 40% for out-of-network.

    i. Once the deductible has been met, coinsurance for prescriptions will be 20%.

[1] Deductibles are subject to change yearly in accordance with IRS regulations.

2. Effective January 1, 2027, redesign the current Health Account Plan (HAP) option with both Anthem and Kaiser. The HAP plan option will have a 10% medical plan premium for full time and part time employees.

    a. Remove yearly biometric health and tobacco screening requirement with Quest

    b. Provide company funded annual contributions to Health Reimbursement Account (HRA) for all enrolled employees.
        i. $1,000 HRA contribution for single coverage
        ii. $2,000 HRA contribution for family coverage
        iii. All funds in an HRA will remain available upon retirement (age 55 with 10 years of service) unless the participant opts out of coverage.
        iv. In the event of an employee's death, HRA account balances will remain available to the covered surviving spouse, provided they continue PG&E sponsored coverage.
        v. Members may use HRA funds for any IRS eligible expenses.

    j. Annual medical plan deductible for in-network services will remain at $1,000 (single) or $2,000 (family).

    k. Annual medical plan deductible for out-of-network services will be $2,000 (single) or $4,000 (family).

    l. Annual medical plan out-of-pocket maximum for in-network will remain at $2,400 (single) or $4,800 (family).

    m. Annual medical plan out-of-pocket maximum for out-of-network will be $4,800 (single) or $9,600 (family).

    n. Once the deductible has been met, coinsurance will be 20% for in-network services and 40% for out-of-network services.

    o. Laboratory testing performed at a Quest Diagnostics facility will be provided free of charge (Anthem HAP only).

    p. Remove free OON preventive care coverage. It is only covered in full if performed In-Network. Standard OON cost shares will apply for OON preventive care (Anthem plans).

    q. Establish Complex Care for Anthem and eliminate Knova Solutions.

3. Part-time and regular status employees will pay the same cost share as full-time employees.

4. Infertility lifetime maximum will be increased from $7,000 to $25,000.

5. Adoption expense reimbursement will be increased from $2,000 to $25,000/per adoption.

6. Allow members to cover non-represented PG&E employees and vice versa.

7. Change the standard list of preventive care services from PG&E custom list to the United States Preventative Services Task Force list (current list in Attachment B3 below).

8. Change from PG&E custom free drug list to Kaiser and Evernorth (formerly Express Scripts) Standard preventive free drug coverage lists as applicable.

9. Effective January 1, 2027, enhance dental benefits as follows:

    a. Redesign current dental plan to offer free preventative coverage.
    b. Add “buy up” enhanced plan option (see Attachment B4 below).
    c. Explore adding another vendor to expanded network choice.

10. Effective January 1, 2027, enhance vision benefits as follows:

    a. Add “buy up” enhanced option and/or explore adding another vendor alongside the existing plan.

11. Hearing Aid benefits provided in LA-13-68 shall continue to be available to active employees so long as they are enrolled in the Active health plan.

12. Explore a different vendor for mental health and substance disorder benefits and Employee Assistance Plan (EAP).

13. Raise company paid life insurance and company paid accidental death and dismemberment (AD&D) from $10,000 to $50,000 each.

Health Plan Designs

Key features	HDHP Administered by Anthem or Kaiser Permanente	HAP Administered by Anthem or Kaiser Permanente
Contribution Rate	7.5%	10%
Health Accounts	Company funded annual contributions to a Health Savings Account (HSA) for all enrolled members who meet HSA eligibility requirements. $800 HSA contribution for single coverage $1,600 HSA contribution for family coverage Members will be eligible to make their own contributions to their HSA account Company funded $500 annual contributions to Limited Purpose Health Reimbursement Account	Company funded annual contributions to Health Reimbursement Account (HRA) for all enrolled coworkers $1,000 HRA contribution for single only coverage $2,000 HRA contribution family coverage All funds in HRA will remain available until retirement In the event of an employee's or retiree's death, HRA account balances will remain available to the covered surviving spouse, provided they continue PG&E sponsored coverage.
Annual deductible	**In-network care:** $1,700 if you have single coverage $3,400 if you have family coverage **Out-of-network care:** $3,400 if you have single coverage $6,800 if you have family coverage	**In-network care:** $1,000 if you have single coverage $2,000 if you have family coverage **Out-of-network care:** $2,000 if you have single coverage $4,000 if you have family coverage
Coinsurance After you meet the annual deductible	**In-network care:** Plan pays 80% of allowable expenses. You're responsible for 20% of allowable expenses. **Out-of-network care:** Plan pays 60% of allowable expenses. You're responsible for 40% of allowable expenses.	**In-network care:** Plan pays 80% of allowable expenses. You're responsible for 20% of allowable expenses. **Out-of-network care:** Plan pays 60% of allowable expenses. You're responsible for 40% of allowable expenses.
Annual out-of-pocket maximum Includes amounts you pay toward the annual deductible	**In-network care:** $3,400 if you have single coverage $6,800 if you have family coverage **Out-of-network care:** $6,800 if you have single coverage $13,600 if you have family coverage	**In-network care:** $2,400 if you have single coverage $4,800 if you have family coverage **Out-of-network care:** $4,800 if you have single coverage $9,600 if you have family coverage

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Key features	HDHP Administered by Anthem or Kaiser Permanente	HAP Administered by Anthem or Kaiser Permanente
Primary care Includes routine physical exams	**Doctor visits *** • Deductible required • **In-network care:** You're responsible for 20% of covered charges • **Out-of-network care:** You're responsible for 40% of covered charges	**Doctor visits** • No deductible • Four free in-network care visits a year per enrolled person; you're responsible for 10% of covered charges for additional visits
Specialty care	• Deductible required • **In-network care:** You're responsible for 20% of covered charges • **Out-of-network care:** You're responsible for 40% of covered charges	• Deductible required • **In-network care:** You're responsible for 20% of covered charges • **Out-of-network care:** You're responsible for 40% of covered charges
Preventive services and immunizations	• No deductible • Free if listed on US Prevention Services Task Force Standard list	• No deductible • Free if listed on US Prevention Services Task Force Standard list
Maternity care	**Office visits**** • Deductible required • **In-network care:** You're responsible for 20% of covered charges • **Out-of-network care:** You're responsible for 40% of covered charges • No deductible • Free **Screenings and tests (e.g., sonograms)** • Deductible required • **In-network care:** You're responsible for 20% of covered charges • **Out-of-network care:** You're responsible for 40% of covered charges **Diagnostics, X-rays and labwork are covered separately.** **Hospital-based delivery** • Deductible required • **In-network care:** You're responsible for 20% of covered charges • **Out-of-network care:** You're responsible for 40% of covered charges **NOTE:** Preauthorization required for delivery and all inpatient services; no penalty for failure to preauthorize inpatient delivery claims. Authorization required for delivery stays beyond 48 hours for vaginal delivery (96 hours for Cesarean section).	**Office visits** • **No deductible** • **Free** **Screenings and tests (e.g., sonograms)** • **Deductible required** • **In-network care:** You're responsible for 20% of covered charges • **Out-of-network care:** You're responsible for 40% of covered charges **Diagnostics, X-rays and labwork are covered separately.** **Hospital-based delivery** • Deductible required • **In-network care:** You're responsible for 20% of covered charges • **Out-of-network care:** You're responsible for 40% of covered charges **Anthem members:** • Preauthorization required for delivery and all inpatient services; no penalty for failure to preauthorize inpatient delivery claims. • Authorization required for delivery stays beyond 48 hours for vaginal delivery (96 hours for Cesarean section).

- * HDHP Primary Care Note: All Primary care Doctor visits that meet the criteria for Free Preventative Services (see Attachment B3) will have no deductible. For all other services, the cost will be applied toward the Deductible.
- ** HDHP Maternity Care Note: All Maternity care Doctor visits that meet the criteria for Free Preventative Services (see Attachment B3) will have no deductible. For all other services, the cost will be applied toward the Deductible.

Attachment B1

Key features	HDHP Administered by Anthem or Kaiser Permanente	HAP Administered by Anthem or Kaiser Permanente
Well-baby care	• No deductible • Free to age two	• No deductible • Free to age two
Infertility services	• Deductible required • **In-network care:** You're responsible for 20% of covered charges • **Out-of-network care:** You're responsible for 40% of covered charges • $25,000 lifetime benefit maximum; includes balances from prior plans	• Deductible required • **In-network care:** You're responsible for 20% of covered charges • **Out-of-network care:** You're responsible for 40% of covered charges • $25,000 lifetime benefit maximum; includes balances from prior plans
Urgent care	• Deductible required • **In-network care:** You're responsible for 20% of covered charges • **Out-of-network care:** You're responsible for 40% of covered charges	Covered as **primary care**—no deductible; you're responsible for 10% of covered charges after the first four free primary care visits in-network or 10% of charges if out of network
Lab tests and X-rays	**Routine preventive screenings listed on US Prevention Services Task Force Standard list** • No deductible • Free **All other procedures, including diagnostic tests and most lab tests** • Deductible required • **In-network care:** You're responsible for 20% of covered charges • **Out-of-network care:** You're responsible for 40% of covered charges **NOTE:** • 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) • Preauthorization is required for advanced imaging procedures; no coverage if not obtained. Check with your health care provider.	**Routine preventive screenings listed on US Prevention Services Task Force Standard list** • No deductible • Free **Laboratory testing performed at a Quest Diagnostics facility will be provided free of charge. All other procedures, including diagnostic tests and most lab tests** • Deductible required • You're responsible for 20% of covered charges • **In-network care:** You're responsible for 20% of covered charges • **Out-of-network care:** You're responsible for 40% 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) • Preauthorization is required for advanced imaging procedures; no coverage if not obtained. Check with your health care provider.

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Attachment B1

Key features	HDHP Administered by Anthem or Kaiser Permanente	HAP Administered by Anthem or Kaiser Permanente
Prescription drugs	**Select drugs are free on Anthem or Kasier standard list, no deductible** **Generic and brand drugs** (preferred and non-preferred) • Deductible required • **Retail:** In-network and out-of-network; you're responsible for 20% of covered charges • **Mail order:** In-network only; you're responsible for 20% of covered charges **NOTE:** • Some preventive prescriptions may be free. Contact Express Scripts for details: **1-800-718-6590**. • Drugs on the Mandatory Mail-Order drug list are covered only at mail order after the first three fills at retail. • 100% penalty may apply for using retail after three fills. • Certain specialty drugs can be obtained through mail order only.	**Select drugs are free on Anthem or Kaiser standard list, no deductible** **Generic and brand drugs** (preferred and non-preferred) • Deductible required (combined with medical deductible) • **Retail:** In-network and out-of-network; you're responsible for 15% of covered charges for generic; 25% for brand (**Anthem members:** Generic Incentive Provision and Step Therapy Provision apply) • **Mail order:** In-network only; you're responsible for 10% of covered charges for generic; 20% for brand **Anthem members:** • Some preventive prescriptions may be free. Contact Express Scripts for details: **1-800-718-6590**. • Drugs on the Mandatory Mail-Order drug list are covered only at mail order after the first three fills at retail. • 100% penalty may apply for using retail after three fills. • Certain specialty drugs can be obtained through mail order only. **Kaiser Permanente members:** No mandatory mail order; you can use a Kaiser Permanente pharmacy or Kaiser Permanente mail order for maintenance drugs.
Chiropractic and Acupuncture	• Deductible required • **In-network care:** You're responsible for 20% of covered charges • **Out-of-network care:** You're responsible for 40% of covered charges **NOTE:** Preauthorization required after five visits per year	• Deductible required • **In-network care:** You're responsible for 10% of covered charges for first five visits per year; 20% for additional visits • **Out-of-network care:** You're responsible for 40% of covered charges **Anthem members:** Preauthorization required after five visits per year **Kaiser Permanente members:** You can self-refer to American Specialty Health (ASH) provider

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Attachment B1

Key features	HDHP Administered by Anthem or Kaiser Permanente	HAP Administered by Anthem or Kaiser Permanente
Mental health and substance use disorder care	Deductible required HDHP provides benefits for: • Outpatient mental health • Inpatient mental health • Outpatient substance use disorder care • Inpatient substance use disorder care	No deductible for outpatient care Deductible required for inpatient care HAP provides benefits for: • Outpatient mental health • Inpatient mental health • Outpatient substance use disorder care • Inpatient substance use disorder care
Applied Behavioral Analysis (ABA) (autism treatment)	• Deductible required • **In-network care:** You're responsible for 20% of covered charges • **Out-of-network care:** You're responsible for 40% of covered charges **Preauthorization required with Carelon Behavioral Health**	• No deductible • Free • No limits through Carelon Behavioral Health **Anthem members:** Carelon Behavioral Health provides this coverage **Kaiser Permanente members:** You may use Carelon Behavioral Health or Kaiser Permanente **Preauthorization required with Carelon Behavioral Health**
Health Care Flexible Spending Account (FSA) You must elect it to participate in it	**If you have an HSA, the Health Care FSA is a Limited-Purpose FSA.** **Before you meet the HDHP deductible, the Limited-Purpose FSA can be used only for:** • Dental • Vision • Dental and vision over-the-counter expenses **After you meet the HDHP deductible, the FSA can be used for all of the above plus:** • Medical • Prescription drug • Mental health and substance use disorder • Eligible over-the-counter health expenses	**Health Care FSA for:** • Medical • Prescription drug • Mental health and substance use disorder • Dental • Vision • Eligible over-the-counter health expenses

Attachment B2

Free Preventive Drug Coverage

Evernorth (Formerly Express Scripts)

https://www.express-scripts.com/art/open_enrollment/StdPreventMedList.pdf

Kaiser

https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/ca/deductible-epo-self-funded-plans-formulary-ca-en.pdf?kp_shortcut_referrer=kp.org/formulary

Attachment B3

Free Preventive Services

A & B Recommendations

A listing of all the Recommendations with a grade of either A or B.

A and B grade recommendations are services that the Task Force most highly recommends implementing for preventive care and that are also relevant for implementing the Affordable Care Act. These preventive services have a high or moderate net benefit for patients.

Topic	Description	Grade	Release Date of Current Recommendation
Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked	The USPSTF recommends 1-time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men aged 65 to 75 years who have ever smoked.	B	December 2019 *
Anxiety Disorders in Adults: Screening: adults 64 years or younger, including pregnant and postpartum persons	The USPSTF recommends screening for anxiety disorders in adults, including pregnant and postpartum persons.	B	June 2023
Anxiety in Children and Adolescents: Screening: children and adolescents aged 8 to 18 years	The USPSTF recommends screening for anxiety in children and adolescents aged 8 to 18 years.	B	October 2022
Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality: Preventive Medication: pregnant persons at high risk for preeclampsia	The USPSTF recommends the use of low-dose aspirin (81 mg/day) as preventive medication after 12 weeks of gestation in persons who are at high risk for preeclampsia. See the Practice Considerations section for information on high risk and aspirin dose.	B	September 2021 *
Asymptomatic Bacteriuria in Adults: Screening: pregnant persons	The USPSTF recommends screening for asymptomatic bacteriuria using urine culture in pregnant persons.	B	September 2019 *
BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with brca1/2 gene mutation	The USPSTF recommends that primary care clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.	B	August 2019 *

Attachment B3

Breast Cancer: Medication Use to Reduce Risk: women at increased risk for breast cancer aged 35 years or older	The USPSTF recommends that clinicians offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects.	B	September 2019 *
Breast Cancer: Screening: women aged 40 to 74 years	The USPSTF recommends biennial screening mammography for women aged 40 to 74 years. †	B	April 2024 *
Breastfeeding: Primary Care Behavioral Counseling Interventions: pregnant and postpartum women	The USPSTF recommends providing interventions or referrals, during pregnancy and after birth, to support breastfeeding.	B	April 2025 *
Cervical Cancer: Screening: women aged 21 to 65 years	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). See the Clinical Considerations section for the relative benefits and harms of alternative screening strategies for women 21 years or older.	A	August 2018 *
Chlamydia and Gonorrhea: Screening: sexually active women, including pregnant persons	The USPSTF recommends screening for gonorrhea in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection.	B	September 2021 *
Chlamydia and Gonorrhea: Screening: sexually active women, including pregnant persons	The USPSTF recommends screening for chlamydia in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection.	B	September 2021 *
Colorectal Cancer: Screening: adults aged 45 to 49 years	The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years. See the "Practice Considerations" section and Table 1 for details about screening strategies.	B	May 2021 *
Colorectal Cancer: Screening: adults aged 50 to 75 years	The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years. See the "Practice Considerations" section and Table 1 for details about screening strategies.	A	May 2021 *
Depression and Suicide Risk in Adults: Screening: adults, including pregnant and postpartum persons, and older adults (65 years or older)	The USPSTF recommends screening for depression in the adult population, including pregnant and postpartum persons, as well as older adults.	B	June 2023 *

Attachment B3

Depression and Suicide Risk in Children and Adolescents: Screening: adolescents aged 12 to 18 years	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.	B	October 2022 *
Falls Prevention in Community-Dwelling Older Adults: Interventions: community-dwelling adults 65 years or older	The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.	B	June 2024
Folic Acid Supplementation to Prevent Neural Tube Defects: Preventive Medication: persons who plan to or could become pregnant	The USPSTF recommends that all persons planning to or who could become pregnant take a daily supplement containing 0.4 to 0.8 mg (400 to 800 mcg) of folic acid.	A	August 2023 *
Gestational Diabetes: Screening: asymptomatic pregnant persons at 24 weeks of gestation or after	The USPSTF recommends screening for gestational diabetes in asymptomatic pregnant persons at 24 weeks of gestation or after.	B	August 2021 *
Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Interventions: adults with cardiovascular disease risk factors	The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.	B	November 2020 *
Healthy Weight and Weight Gain In Pregnancy: Behavioral Counseling Interventions: pregnant persons	The USPSTF recommends that clinicians offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.	B	May 2021
Hepatitis B Virus Infection in Adolescents and Adults: Screening: adolescents and adults at increased risk for infection	The USPSTF recommends screening for hepatitis B virus (HBV) infection in adolescents and adults at increased risk for infection. See the Practice Considerations section for a description of adolescents and adults at increased risk for infection.	B	December 2020 *
Hepatitis B Virus Infection in Pregnant Women: Screening: pregnant women	The USPSTF recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit	A	July 2019 *
Hepatitis C Virus Infection in Adolescents and Adults: Screening: adults aged 18 to 79 years	The USPSTF recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years.	B	March 2020 *

Attachment B3

High Body Mass Index in Children and Adolescents: Interventions: children and adolescents 6 years or older	The USPSTF recommends that clinicians provide or refer children and adolescents 6 years or older with a high body mass index (BMI) (≥95th percentile for age and sex) to comprehensive, intensive behavioral interventions. See the Practice Considerations section for more information about behavioral interventions.	B	June 2024 *
Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened. See the Clinical Considerations section for more information about assessment of risk, screening intervals, and rescreening in pregnancy.	A	June 2019 *
Human Immunodeficiency Virus (HIV) Infection: Screening: pregnant persons	The USPSTF recommends that clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown.	A	June 2019 *
Hypertension in Adults: Screening: adults 18 years or older without known hypertension	The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A	April 2021 *
Hypertensive Disorders of Pregnancy: Screening: asymptomatic pregnant persons	The USPSTF recommends screening for hypertensive disorders in pregnant persons with blood pressure measurements throughout pregnancy.	B	September 2023 *
Intimate Partner Violence and Caregiver Abuse of Older or Vulnerable Adults: Screening: women of reproductive age, including pregnant and postpartum women	The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age, including those who are pregnant and postpartum. See the "Practice Considerations" section for information on evidence-based multicomponent interventions and for information on IPV in men.	B	June 2025 *
Latent Tuberculosis Infection in Adults: Screening: asymptomatic adults at increased risk of latent tuberculosis infection (ltbi)	The USPSTF recommends screening for LTBI in populations at increased risk. See the "Assessment of Risk" section for additional information on adults at increased risk.	B	May 2023 *
Lung Cancer: Screening: adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B	March 2021 *

Attachment B3

Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.	A	January 2019 *
Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years with 1 or more risk factors for osteoporosis	The USPSTF recommends screening for osteoporosis to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk for an osteoporotic fracture as estimated by clinical risk assessment. See the "Practice Considerations" section for more information on risk assessment and screening tests.	B	January 2025 *
Osteoporosis to Prevent Fractures: Screening: women 65 years or older	The USPSTF recommends screening for osteoporosis to prevent osteoporotic fractures in women 65 years or older. See the "Practice Considerations" section for more information on screening tests.	B	January 2025 *
Perinatal Depression: Preventive Interventions: pregnant and postpartum persons	The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.	B	February 2019
Prediabetes and Type 2 Diabetes: Screening: asymptomatic adults aged 35 to 70 years who have overweight or obesity	The USPSTF recommends screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity. Clinicians should offer or refer patients with prediabetes to effective preventive interventions.	B	August 2021 *
Prevention of Acquisition of HIV: Preexposure Prophylaxis: adolescents and adults at increased risk of hiv	The USPSTF recommends that clinicians prescribe preexposure prophylaxis using effective antiretroviral therapy to persons who are at increased risk of HIV acquisition to decrease the risk of acquiring HIV. See the Practice Considerations section for more information about identification of persons at increased risk and about effective antiretroviral therapy.	A	August 2023 *
Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions: children younger than 5 years	The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.	B	December 2021 *
Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions: children younger than 5 years	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride.	B	December 2021 *
Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy-related care visit	The USPSTF strongly recommends Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004 *

Attachment B3

Rh(D) Incompatibility: Screening: unsensitized rh(d)-negative pregnant women	The USPSTF recommends repeated Rh(D) antibody testing for all unsensitized Rh(D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh(D)-negative.	B	February 2004 *
Sexually Transmitted Infections: Behavioral Counseling: sexually active adolescents and adults at increased risk	The USPSTF recommends behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs). See the Practice Considerations section for more information on populations at increased risk for acquiring STIs.	B	August 2020 *
Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children	The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.	B	March 2018 *
Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication: adults aged 40 to 75 years who have 1 or more cardiovascular risk factors and an estimated 10-year cardiovascular disease (cvd) risk of 10% or greater	The USPSTF recommends that clinicians prescribe a statin for the primary prevention of CVD for adults aged 40 to 75 years who have 1 or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater.	B	August 2022 *
Syphilis Infection During Pregnancy: Screening: asymptomatic pregnant women	The USPSTF recommends early, universal screening for syphilis infection during pregnancy; if an individual is not screened early in pregnancy, the USPSTF recommends screening at the first available opportunity.	A	May 2025 *
Syphilis Infection in Nonpregnant Adolescents and Adults: Screening: asymptomatic, nonpregnant adolescents and adults who are at increased risk for syphilis infection	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.	A	September 2022 *
Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and US Food and Drug Administration (FDA)--approved pharmacotherapy for cessation to nonpregnant adults who use tobacco.	A	January 2021 *
Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions: pregnant persons	The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.	A	January 2021 *
Tobacco Use in Children and Adolescents: Primary Care Interventions: school-aged children and adolescents who have not started to use tobacco	The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.	B	April 2020 *
Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.	B	November 2018 *
Unhealthy Drug Use: Screening: adults age 18 years or older	The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)	B	June 2020
Vision in Children Ages 6 Months to 5 Years: Screening: children aged 3 to 5 years	The USPSTF recommends vision screening at least once in all children aged 3 to 5 years to detect amblyopia or its risk factors.	B	September 2017 *
Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults	The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.	B	September 2018 *

†The Department of Health and Human Services, under the standards set out in revised Section 2713(a)(5) of the Public Health Service Act and Section 223 of the 2021 Consolidated Appropriations Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force. To see the USPSTF 2016 recommendation on breast cancer screening, go to http://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening1.

*Previous recommendation was an "A" or "B."

Attachment B4

DENTAL

	New Base Plan Design	"Buy Up" Enhanced Plan
Preventive	**100%**	**100%**
Basic	**85%**	**90%**
Major	**85%**	**90%**
Deductible	**Passive PPO: $25/$75 Premier: $50/$150**	**Passive PPO: $25/$75 Premier: $50/$150**
Annual max	**$2,500**	**$2,500**
Orthodontics	**50%**	**50%**
Lifetime Orthodontics max	**$2,000**	**$3,000**
Out of Pocket Max reimbursement	**80th percentile**	**80th percentile**

Attachment B5

VISION

Details of buy up option or second vendor will be available during open enrollment.

Attachment B6

BASIC LIFE INSURANCE and ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Company will offer each employee basic life and accidental death and dismemberment (AD&D) of $50,000 at no cost.

Attachment B7

The following will be a Memorandum of Understanding (MOU) signed upon ratification of the agreement.

The Company and the union discussed the impact of January 1, 2027 changes to active medical plans for deductibles and out of pocket maximums when members utilize Out of Network (OON) providers. The intent of this Memorandum of Understanding (MOU) is to define OON, provide clarity on when the OON Deductible will apply, clarify when claims that would normally be treated as OON will be treated and paid as in-network, and document the process for Appealing a Denial of Pre-Service or Post-Service Request for In-Network Treatment of Out-of-Network Provider.

Consistent with the active medical plan and current administrative procedures, the plan administrator of the active employee medical plan has authorization to determine whether an Out-of-Network provider should be treated as an In-Network provider subject to the guidelines summarized below. On an annual basis, geographical areas shall be identified as Rural, Suburban, or Urban based on the definitions below.

Urban – Population density is greater than 3,000 persons per square mile.

Suburban – Population density is between 1,000 and 3,000 persons per square mile.

Rural – Population density is less than 1,000 persons per square mile.

The table below is utilized to determine if there are sufficient numbers of in-network providers within the mileage specified from the member's residence for services to be considered in-network or out-of-network (OON):

Provider	Urban	Suburban	Rural
PCPs	Two within five miles	Two within 10 miles	Two within 20 miles
OB/GYNs	Two within five miles	Two within 10 miles	Two within 20 miles
Pediatricians	Two within five miles	Two within 10 miles	Two within 20 miles
All other specialists	Two within five miles	Two within 10 miles	Two within 20 miles
Acute care hospitals	One within five miles	One within 10 miles	One within 25 miles

1. If the Criteria for In-Network providers from the above table are not met, providers chosen by the member that are licensed in the area of care being sought by the member shall be treated as In-Network for purposes of coverage levels, deductibles, and out of pocket contributions by the member. Note: Authorization does not guarantee the provider will bill the insurance directly so the member may be required to pay up front and submit for reimbursement.

2. If there is an insufficient number of in-network providers in a given specialty (e.g. cardiologist, endocrinologist, dermatologist etc.) within the miles listed in the table above, an OON specialist that is licensed in the area of care being sought by the member and chosen by the member, shall be treated as In-Network.

3. Example: A member lives in San Luis Obispo and needs to see an Orthopedist. There is only one In-network Orthopedist within the mileage limits above. The member would be able to submit a pre-service request to treat an OON Orthopedist as In-Network and once

the plan administrator confirms this meets this MOU's guidelines, all claims would be treated as In-Network.

Note: Authorization does not guarantee the provider will bill the insurance directly so the member may be required to pay up front and submit for reimbursement.

4. Even if the conditions in the table above are met for a sufficient number of in-network providers, if an In-Network provider is not available within a medically necessary timeframe, the member may request a pre-service authorization for an OON provider to be treated as In-Network. If the request meets the conditions of this MOU, such request shall be granted and the authorized provider who is licensed in the area of care being sought by the member, shall be treated as in-network.

5. If an In-Network provider refers a member to an OON provider and the conditions in this MOU are met (e.g. not enough providers in the network for that specialty), the OON provider the member is referred to shall be treated as In-Network so long as the provider is licensed in the area of care being sought by the member.

6. If a member receives treatment at an In-Network facility, all claims resulting from the treatment will be treated as In-Network.
    a. Example: A member is hospitalized at an In-Network facility and the treating Anesthesiologist is OON, the claims from the Anesthesiologist will be treated as In-Network.

If an In-Network provider becomes OON, the member may appeal to request that claims with the provider continue to be covered as In-Network for 180 days. Such request shall be granted upon verification by the plan administrator the conditions of this MOU are met.

7. Once an In-Network authorization has been granted for an OON provider, said authorization shall remain in effect for 180 days regardless if other providers are added to the network. If adequate coverage with an in-network provider becomes available during the 180-day period, the medical plan administrator will notify the participants of new network provider availability, and the participant can decide to move to the in-network provider at the end of their 180-day period, or continue with the OON provider and have claims processed as OON. Coverage during the 180-day period for the authorized OON provider will be treated as In-Network. Members are able to check in-network availability online, via 800 number, or in the Sydney app.

8. The plan administrator retains discretion to deny approval of specific Out-of-Network providers as an In-Network provider if the conditions of this MOU are not met.

9. Denial of a request for In Network treatment of an Out-of-Network provider, or other disputes regarding Out-of- Network coverage, will not be subject to the Parties' grievance procedures under the collective bargaining agreement. However, a member can appeal

a denial of a request for In-Network services from an Out-of-Network provider, as described below.

Process for Appealing a Denial of Pre-Service or Post-Service Request for In-Network Treatment of Out-of-Network Provider:

1. Member appeals through the plan administrator appeal process (once an Advocacy Services Provider is established, the appeal process will start with them).
2. If the appeal is denied, PG&E shall be notified of the denial and the denial shall be forwarded to PG&E Benefits for evaluation.

RETIREE MEDICAL

Update subsidies to replace those currently being provided under Retiree Medical Employer Contribution (RMEC) and Retiree Medical Savings Account (RMSA)

Establish a Retiree Health Reimbursement Account (RHRA) to credit the new pre-Medicare and Medicare subsidy replacements as follows:

Pre-Medicare Retirees and Pre-Medicare eligible spouses - $15,000 each per year

Medicare Retirees and Medicare eligible spouses - $1,800 each per year

Current notional accounts to be updated (RMEC/RMSA) to eliminate balance (no grandfathering option) and set pre-Medicare and post Medicare subsidy levels with an automatic escalation (cost of living adjustment).

Improve retiree experience – concierge support for plan selection and enrollment. Expert, unbiased guidance from licensed benefit advisors.

Pensioners would pay premium directly to the carrier of the coverage they select instead of monthly pension check and be reimbursed through RHRA.

Eliminate PG&E sponsored retiree major medical options and leverage the marketplace to provide access to more cost-effective health plans.

Retiree Health Reimbursement Account (RHRA):

1. No RHRA funds accumulation limit.

2. Any HRA funds accumulated while active transfer to the RHRA upon retirement as long as the employee is eligible (age 55 with 10 Years of Service) until balance is depleted.

3. Prior RHRA funds balance maintained when retirees become Medicare eligible.

4. All IRS eligible expenses qualify for RHRA reimbursement.

5. Accumulated RHRA funds will be available to retirees whether or not they are enrolled in the PG&E selected Individual Insurance exchange.

6. Debit card to be provided to participants for qualified expenses payment – as long as administratively possible.

7. Automatic annual funding rate escalator of 3% for the Pre-Medicare RHRA subsidy amount.

8. Automatic annual funding rate escalator of 3% for the Medicare RHRA subsidy amount.

9. Funding level of $15,000 for Pre-Medicare eligible retiree only/Pre-Medicare eligible spouse per year.

10. Funding level of $1,800 for Medicare eligible retiree only/Medicare eligible spouse per year.

11. RHRA funds of annual funding amount available upon effective date of RHRA plan as long as the retiree is enrolled in the PG&E selected Individual Insurance Exchange.

12. RHRA funding once per year in January as long as the retiree is enrolled in the PG&E selected Individual Insurance Exchange.

13. If a retiree is Medicare eligible and has a RHRA eligible spouse who is not Medicare eligible, the spouse RHRA will be funded at the Pre-Medicare retiree rate while the retiree RHRA will be funded at the Medicare rate and vice versa.

14. In the event a retiree passes away with an eligible surviving spouse on their RHRA at the time of passing, the surviving spouse shall continue to have their RHRA funded annually as long as their eligibility for the plan continues.

15. Hearing Aid benefits provided in LA-13-68 shall continue to be available for retirees whether or not they are enrolled in the PG&E Exchange

16. In accordance with the Affordable Care Act, a participant who chooses to take the Affordable Care Act Premium Tax Credit would have any prior RHRA funds frozen and unavailable until such time as they choose to use the provided employer subsidy or becomes Medicare eligible