EDISON INTERNATIONAL®

2025 HEALTH PLANS COMPARISON

for Flex Retirees

The Health Plans Comparison is a summary of our medical, prescription drug, dental, and vision plans, which includes a side-by-side comparison of coverage details like deductibles, out-of-pocket maximums, copays, and coinsurance.

ANNUAL ENROLLMENT

Oct. 21 through Nov. 1, 2024

PICKING THE RIGHT PLAN

It's Annual Enrollment season, your opportunity to evaluate your benefit plan options and make changes for the following plan year. Annual Enrollment for 2025 will begin on Oct. 21 and will continue through Nov. 1.

Selecting coverage for you and your family can be intimidating. Generally, you are locked into the plan you select for the plan year unless you experience a qualified life event, so it's important to choose wisely. Understanding how your health insurance works now can save you money and frustration in the future.

To choose a plan that is best suited for you and your family, take a few moments to learn about the things to consider when evaluating your options this Annual Enrollment.

Understand the Types of Health Insurance Plans Available

The type of plan you choose determines your out-of-pocket costs and which providers you can visit.

Pre-Medicare Plans			
Plan Type	**Do you have to stay in-network to get coverage?**	**Do procedures & specialists require a referral?**	**Overview**
Preferred Provider Organization (PPO)	No, but in-network care is typically less expensive.	No.	More provider options and typically no required referrals, but there may be prior authorization required depending on services requested and higher out-of-pocket costs.
Exclusive Provider Organization (EPO)	Yes, except for emergencies.	Not typically.	Lower out-of-pocket costs and usually no required referrals, but less freedom to choose providers. Some procedures/ services require authorization.

Medicare Plans			
Plan Type	**Do you have to stay in-network to get coverage?**	**Do procedures & specialists require a referral?**	**Overview**
Preferred Provider Organization (PPO)	No. You have the ability to access any Medicare approved provider who is willing to treat you and accept the plan, and you will have the same benefits and cost share both in and out-of-network.	No.	More provider options and no referrals required. Some procedures/services require authorization.
Health Maintenance Organization (HMO)	Yes, except for emergencies.	Yes, typically.	Lower out-of-pocket costs and a primary doctor who coordinates your care for you, but less freedom to choose providers. Some procedures/ services require authorization.

Estimate Your Family's Medical Needs

While it is impossible to predict every medical expense you may have for the next plan year, looking back at previous years can help you identify trends and estimate out-of-pocket costs. If you are anticipating specific medical expenses in 2025 (e.g., elective surgery) or changing the number of your covered dependents (e.g., getting married), be sure to factor those into your 2025 estimate.

Compare Networks

You'll generally pay less to see an in-network provider because the insurance company has negotiated lower rates with these providers. When you visit an out-of-network provider, and depending on which plan you are in, you may be responsible for a higher portion of the cost. Some plans (such as an EPO or HMO) do not permit care from an out-of-network provider.

If you want to keep seeing your current medical provider, check the plan's provider directory to see if they will be in-network. If you don't have a preferred provider, consider choosing a plan with a large network so you have more choices for finding a provider that's right for your situation.

Compare Out-of-Pocket Costs

Out-of-pocket costs can occur in different forms, including:

- **Copayment:** This is a flat fee (such as $30) that you pay each time you receive a health care service or procedure.
- **Deductible:** This is a specified amount you pay for covered medical care before your insurance starts paying.
- **Coinsurance:** This is the percentage (such as 10%) of a medical charge that you pay after your deductible has been met.
- **Out-of-pocket maximum:** This is the most you'll pay out-of-pocket for covered health care for the plan year. Once you reach this maximum, your insurance pays the rest for the remainder of the plan year. At Edison, you have separate out-of-pocket maximums for your medical care and prescription drugs.

Consider Premium Costs

The premium is the sum you pay each month to participate in the health plan. Think of this as the "sticker price" of the plan. Edison contributes a large portion of this cost for medical and dental coverage, and contributes 100% of the cost for vision coverage.

A plan with higher monthly premiums but lower out-of-pocket costs might be the better choice if:	**A plan with lower monthly premiums but higher out-of-pocket costs might be the better choice if:**
▪ You see a primary physician or a specialist frequently. ▪ You frequently need emergency care. ▪ You're expecting a baby, plan to have a baby or have small children. ▪ You have a planned surgery coming up. ▪ You've been diagnosed with a chronic condition such as diabetes or cancer.	▪ You can't afford the higher monthly premiums for a plan with lower out-of-pocket costs. ▪ You're in good health and rarely see a doctor.

You can view premiums when you access your 2025 Annual Enrollment event on *EIX Benefits Connection* (eixbenefits.com).

Evaluate Your Options

While Edison offers several health care options to retirees and their dependents, there are other Medicare plan options available to you in the marketplace. Depending on your care needs and estimated out-of-pocket and premium costs, a plan offered outside of Edison may be a better fit for your health and financial situation.

SSDC Insurance Agency has licensed professionals that can help you compare plans available outside of Edison to find the best medical and prescription drug plan for you. SSDC's consultation services are provided to you at no cost.

For assistance, please contact SSDC at (866) 587-1661 to speak to an agent. Agents are available Monday through Friday 6:00 a.m. to 3:00 p.m., Pacific time.

As you evaluate plans offered by Edison and in the marketplace, some important considerations to keep in mind:

- Look at all components of outside plans. Generally, the Edison plans have prescription benefits richer than most marketplace plans.
- During Annual Enrollment, you can choose to opt out of your Edison medical coverage for the upcoming plan year. If you would like to return to the Edison medical plans, you can make an election to resume coverage during Annual Enrollment.
- While you can opt out of medical coverage and then resume coverage at a later date, this is not the same for dental and vision coverage. If you opt out of dental and/or vision coverage and do not have group coverage elsewhere, you cannot resume coverage at a later date. See page 20 for more information.

MEDICAL AND PRESCRIPTION DRUG COVERAGE

You can enroll in one of our medical plan options based on your Medicare eligibility. If you enroll in our medical coverage, you and any covered dependents will be automatically enrolled in prescription drug coverage at no additional cost.

Below are the medical and prescription drug plans we offer:

Medical Plan Options — Pre-Medicare		
Plan	**Prescription Drug Coverage**	**Availability**
Aetna Nationwide EPO	Express Scripts	Nationwide
Aetna PPO 90/70	Express Scripts	Nationwide
Kaiser Permanente EPO	Kaiser Permanente	In California only

Medical Plan Options — Medicare		
Plan	**Prescription Drug Coverage**	**Availability**
Aetna HMO Medicare Advantage Plan (MAP)	Express Scripts Medicare	In California only[1]
Aetna PPO MAP	Express Scripts Medicare	Nationwide
Aetna PPO 90/70 Medicare Coordinated Plan	Express Scripts Medicare	Nationwide
Kaiser Permanente Senior Advantage MAP	Kaiser Permanente	In California only

[1] *Beginning in 2025, closed to new enrollees outside of California. Retirees currently residing outside of California and enrolled in the HMO MAP can retain their coverage.*

How PPO, HMO and EPO Medical Plans Work

PPO: After you meet an annual deductible, both you and the plan each pay a percentage of your eligible expenses, known as coinsurance. Not all services require you to meet your deductible first, such as in-network preventive care. You can receive care from any provider, but when you see an in-network provider, your out-of-pocket cost will almost always be less.

PPO MAP: You can see any provider (whether in the network or not), and you pay the same out-of-pocket cost for both covered in-network and out-of-network medical benefits as long as the provider is eligible to receive Medicare payment and willing to bill and accept payment from the plan.

HMO: There is no annual deductible and most eligible expenses require you to pay a flat dollar amount, known as a copay. You must select a primary care physician (PCP) who will coordinate all of your care. All medical services must be received from your HMO's network of providers.

- *Geographic Service Area:* You and any covered dependents must live and receive medical care within the plan's geographic service area if you enroll in an HMO plan. Out-of-area medical services may not be covered, resulting in your financial responsibility for any costs incurred.

EPO: Like an HMO, an EPO has no annual deductible and most eligible expenses require you to pay a copay. Depending on the EPO you elect, you may or may not need to select a PCP to coordinate your care. You are responsible for ensuring all of your medical services are received from your EPO's network of providers.

What is a Medicare Advantage Plan (MAP)?

Medicare Advantage Plans (sometimes called "Part C" plans) are offered by Medicare-approved private companies that must follow rules set by Medicare. These "bundled" plans include Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). In most cases, these plans are offered by an HMO or PPO and you'll need to use health care providers who participate in the plan's network.

If You and/or a Covered Spouse/Registered Partner are Eligible for Medicare

You and/or a covered spouse/registered partner must be enrolled in Medicare Parts A and B to enroll in one of our medical plans that integrates with Medicare. Children, even if disabled, are not eligible for our medical plans that integrate with Medicare.

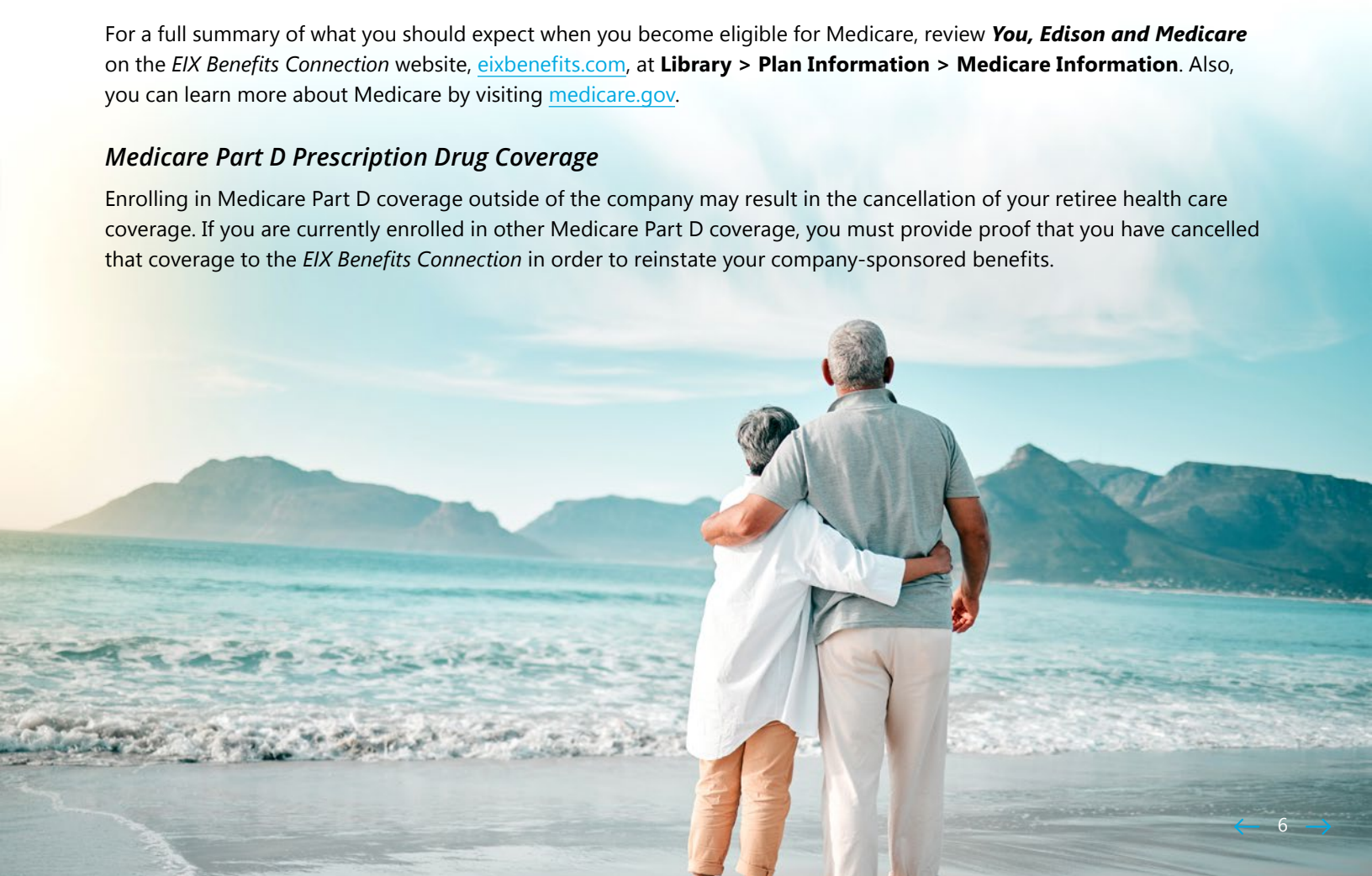
You may see a difference in generic drug costs when you move from pre-Medicare to Medicare-eligible (i.e., Express Scripts to Express Scripts Medicare), which may be lower or higher. The difference in cost is due to Express Scripts Medicare having a different drug list and pricing than its pre-Medicare counterpart, Express Scripts. In any case, you will pay no more than your Edison coinsurance or copayment.

If you and a covered spouse/registered partner are a combination of Medicare-eligible and pre-Medicare, you must enroll in medical plans with the same carrier. For example, if you are Medicare-eligible and elect the Kaiser Senior Advantage MAP, your pre-Medicare spouse/registered partner must enroll in the Kaiser Permanente EPO.

For a full summary of what you should expect when you become eligible for Medicare, review ***You, Edison and Medicare*** on the *EIX Benefits Connection* website, eixbenefits.com, at **Library > Plan Information > Medicare Information**. Also, you can learn more about Medicare by visiting medicare.gov.

Medicare Part D Prescription Drug Coverage

Enrolling in Medicare Part D coverage outside of the company may result in the cancellation of your retiree health care coverage. If you are currently enrolled in other Medicare Part D coverage, you must provide proof that you have cancelled that coverage to the *EIX Benefits Connection* in order to reinstate your company-sponsored benefits.



COMPARISON OF KEY MEDICAL PLAN FEATURES

Pre-Medicare Plans

The following plans are available to those who ***will not*** be eligible for Medicare by Jan. 1, 2025.

	Preferred Provider Organization (PPO)		Exclusive Provider Organization (EPO)	
	Aetna PPO 90/70 *Choice POS II (PPO 90/70)*[1]		**Aetna Nationwide EPO** *Open Access Aetna Select*[1]	**Kaiser Permanente EPO**
Plan Features	*In-Network*	*Out-of-Network*	*Network Only*	*Network Only*
Annual Deductible:				
▪ **Individual**	$575		None	None
▪ **Family**	$1,150			
Annual Out-of-Pocket Maximum	$3,000/individual $6,000/family		$1,190/individual $2,380/family	$1,190/individual $2,380/family
Lifetime Maximum	None		None	None
Physician:				
▪ **Office visits (including specialists)**	▪ $40 copay each visit	▪ Plan pays 70% after deductible	▪ $30 copay each visit	▪ $30 copay each visit
▪ **Urgent care**	▪ $40 copay each visit	▪ Plan pays 70% after deductible	▪ $30 copay each visit	▪ $30 copay each visit
▪ **Hospital visits**	▪ Plan pays 90% after deductible	▪ Plan pays 70% after deductible	▪ No copay	▪ No copay
▪ **Surgery**	▪ 90% after deductible	▪ Plan pays 70% after deductible	▪ No copay	▪ No copay
Hospital:				
▪ **Hospital per admission copay**	▪ $250 copay	▪ Plan pays 70% after deductible	▪ $250 per admission copay	▪ $250 per admission copay
▪ **Outpatient surgery**	▪ Plan pays 90% after deductible	▪ Plan pays 70% after deductible	▪ No copay	▪ No copay
▪ **Skilled nursing facility**	▪ $250 copay and Plan pays 90% after deductible (up to 100 days/calendar year)	▪ $250 copay and Plan pays 90% after deductible (up to 100 days/calendar year)	▪ $250 per admission copay (up to 100 days/ calendar year)	▪ $250 per admission copay (up to 100 days/ calendar year)
Emergency Room	$150 copay (applies to hospital emergency room charges only; copay waived if admitted as an inpatient)			
Radiology (Outpatient)	Plan pays 90% after deductible	Plan pays 70% after deductible	No copay	No copay
Lab (Outpatient)	Plan pays 90% after deductible	Plan pays 70% after deductible	No copay	No copay
Ambulance	No copay	No copay	No copay	No copay
Rehabilitation (physical, occupational, speech, pulmonary, cardiac)	Plan pays 90% after deductible	Plan pays 70% after deductible	$30 copay each visit	$30 copay each visit

See footnotes on page 8.

(continued)

Pre-Medicare Plans (continued)

Plan Features	Preferred Provider Organization (PPO)		Exclusive Provider Organization (EPO)	
	Aetna PPO 90/70 *Choice POS II (PPO 90/70)*[1]		**Aetna Nationwide EPO** *Open Access Aetna Select*[1]	**Kaiser Permanente EPO**
	In-Network	*Out-of-Network*	*Network Only*	*Network Only*
Behavioral Health:				
▪ **Inpatient**	▪ $250 copay and Plan pays 90% after deductible	▪ Plan pays 70% after deductible	▪ $250 per admission copay	▪ $250 per admission copay
▪ **Outpatient**	▪ $40 copay each visit	▪ Plan pays 70% after deductible	▪ $30 copay each visit	▪ $30 copay each visit
Preventive Care[2]	No charge, deductible waived	Plan pays 70% after deductible	No copay	No copay
Acupuncture (up to 30 visits per calendar year)	$40 copay each visit	Plan pays 70% after deductible	$30 copay each visit	$30 copay each visit
Allergy Testing/ Treatment	$40 copay each visit	Plan pays 70% after deductible	No copay	No copay
Chiropractic Services (up to 30 visits per calendar year)	$40 copay each visit	Plan pays 70% after deductible	$30 copay each visit	$30 copay each visit
Durable Medical Equipment	Plan pays 90% after deductible	Plan pays 70% after deductible	No copay	No copay
Prescription Drugs[3] **(Closed Formulary)**	Annual out-of-pocket maximum: $1,810 individual; $3,620 family			
▪ **Maintenance medications**	▪ **Express Scripts:** 90-day supply when fulfilled through mail-order pharmacy or contracted retail pharmacy; **Kaiser:** 90-day supply when fulfilled through mail order or at a Kaiser facility			
▪ **Retail pharmacy**	▪ Plan pays 90% for generic drugs and 80% for brand-name drugs purchased at retail pharmacies (up to a 34-day supply)			
▪ **Specialty pharmacy**	▪ Plan pays 90% for generic drugs and 80% for brand-name drugs purchased through the contracted specialty pharmacy (up to a 34-day supply)			
▪ **Mail-order pharmacy**	▪ Plan pays 90% for generic drugs and 80% for brand-name drugs purchased through the contracted mail-order pharmacy (up to a 90-day supply)			

[1] *Indicates Aetna plan name.*

[2] *Check with your plan for a complete list of covered preventive care services.*

[3] *Kaiser Permanente members must dispense prescriptions at a Kaiser facility.*

Medicare PPO Plans

The following plans are available to those who ***will*** be eligible for Medicare by Jan. 1, 2025.

Plan Features	Preferred Provider Organization (PPO)				
	Aetna PPO 90/70 Medicare Coordinated Plan[1] *Choice POS II (PPO 90/70)[2]*			**Aetna PPO MAP** *Medicare (S02) ESA PPO (MAP)[2]*	
	In-Network *Participating Providers*	***Out-of-Network*** *Non-Participating Providers*	***Opt-Out Providers[3]***	***In-Network***	***Out-of-Network***
Annual Deductible:				None	
▪ **Individual**	▪ $0	▪ $0	▪ $0		
▪ **Family**	▪ $0	▪ $0	▪ $0		
Annual Out-of-Pocket Maximum	N/A	N/A	N/A	$3,000/individual	
Lifetime Maximum	None	None	None	None	
Physician:					
▪ **Office visits (including specialists)**	▪ $0 copay	▪ $0 copay	▪ $0 copay	▪ $40 copay each visit	
▪ **Urgent care**	▪ $0 copay	▪ $0 copay	▪ $0 copay	▪ $40 copay each visit	
▪ **Hospital visits**	▪ $0 copay	▪ $0 copay	▪ $0 copay	▪ Covered under inpatient facility benefit	
▪ **Surgery**	▪ $0 copay	▪ $0 copay	▪ $0 copay	▪ $0	
Hospital:					
▪ **Hospital per admission copay**	▪ $0 copay	▪ $0 copay	▪ $0 copay	▪ $250 per stay	
▪ **Inpatient care**	▪ $0 copay	▪ $0 copay	▪ $0 copay	▪ $0	
▪ **Outpatient surgery**	▪ $0 copay	▪ $0 copay	▪ $0 copay	▪ $0	
▪ **Skilled nursing facility**	▪ $0 per day, days 1-100 (limited to 100 days per Medicare Benefit Period)	▪ $0 per day, days 1-100 (limited to 100 days per Medicare Benefit Period)	▪ $0 per day, days 1-100 (limited to 100 days per Medicare Benefit Period)	▪ $0 per day, days 1-100 (limited to 100 days per Medicare Benefit Period)	
Emergency Room	$0 copay	$0 copay	$0 copay	$125 (waived if admitted)	
Radiology (Outpatient)	$0 copay	$0 copay	$0 copay	$0	
Lab (Outpatient)	$0 copay	$0 copay	$0 copay	$0	
Ambulance	$0 copay	$0 copay	$0 copay	$0	

See footnotes on page 11.

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Medicare PPO Plans (continued)

Plan Features	Preferred Provider Organization (PPO)				
	Aetna PPO 90/70 Medicare Coordinated Plan[1] *Choice POS II (PPO 90/70)[2]*			**Aetna PPO MAP** *Medicare (S02) ESA PPO (MAP)[2]*	
	In-Network *Participating Providers*	***Out-of-Network*** *Non-Participating Providers*	***Opt-Out Providers[3]***	***In-Network***	***Out-of-Network***
Rehabilitation (physical, occupational, speech, pulmonary, cardiac)	$0 copay	$0 copay	$0 copay	$40 ($20 for pulmonary rehabilitation)	
Behavioral Health: ▪ **Inpatient** ▪ **Outpatient**	▪ $0 copay ▪ $0 copay	▪ $0 copay ▪ $0 copay	▪ $0 copay ▪ $0 copay	▪ $250 per stay ▪ $40	
Preventive Care[4]	$0 copay	$0 copay	$0 copay	No charge	
Acupuncture (up to 30 visits per calendar year)	$0 copay	$0 copay	$0 copay	$40	
Allergy Testing/ Treatment	$0 copay	$0 copay	$0 copay	$40	
Chiropractic Services (up to 30 visits per calendar year)	$0 copay	$0 copay	$0 copay	$20	
Durable Medical Equipment	$0 copay	$0 copay	$0 copay	$0	

See footnotes on page 11.

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Medicare PPO Plans (continued)

Plan Features	Preferred Provider Organization (PPO)				
	Aetna PPO 90/70 Medicare Coordinated Plan[1] *Choice POS II (PPO 90/70)[2]*			**Aetna PPO MAP** *Medicare (S02) ESA PPO (MAP)[2]*	
	In-Network *Participating Providers*	***Out-of-Network*** *Non-Participating Providers*	***Opt-Out Providers[3]***	***In-Network***	***Out-of-Network***
Prescription Drugs (Closed Formulary)	Annual out-of-pocket maximum: $1,810 per person For each prescription, you pay your coinsurance up to a maximum of $150 until you reach the annual out-of-pocket maximum (Express Scripts Medicare only)				
▪ **Maintenance medications**	▪ 90-day supply when fulfilled through mail-order pharmacy or contracted retail pharmacy				
▪ **Retail pharmacy**	▪ Plan pays 90% for generic drugs and 80% for brand-name drugs purchased at retail pharmacies (up to a 34-day supply)				
▪ **Specialty pharmacy**	▪ Plan pays 90% for generic drugs and 80% for brand-name drugs purchased through the contracted specialty pharmacy (up to a 34-day supply)				
▪ **Mail-order pharmacy**	▪ **Express Scripts Medicare:** Plan pays 95% for generic drugs and 80% for brand-name drugs purchased through the contracted mail-order pharmacy (up to a 90-day supply) ▪ **Kaiser Permanente:** Plan pays 90% for generic drugs and 80% for brand-name drugs purchased through the contracted mail-order pharmacy (up to a 90-day supply)				

[1] *For **services covered by Medicare and Aetna**, Aetna will **waive** any member responsibility, and will coordinate up to 100% of any remaining allowed charges.*

- *In most cases, this means you will not owe anything to the provider once Medicare and Aetna have paid.*
- *Exceptions to this include services rendered by providers who will not bill Medicare or the services are not covered by the plan.*
- *In cases where the physician is unwilling to bill Medicare, Aetna becomes the primary payer and pays according to the schedule of benefits. You are responsible for all expenses not paid by Aetna.*

For services not covered by Medicare but covered by the Aetna plan, the Aetna plan will pay primary.

[2] *Indicates Aetna plan name.*

[3] *"Opt-Out Providers" are providers who choose not to work with Medicare.*

[4] *Check with your plan for a complete list of covered preventive care services.*

Medicare Coordination of Benefits for the Aetna Choice POS II (PPO 90/70)

Under the Medicare Coordinated Plan, the allowed fees and coordination of benefits depends upon the type of provider your visit. *See chart below.*

For services covered by Medicare and Aetna, Aetna will waive any member responsibility, and will coordinate up to 100% of any remaining allowed charges.

- In most cases, this means you will not owe anything to the provider once Medicare and Aetna have paid.
- Exceptions to this include services rendered by providers who will not bill Medicare.
- In cases where the physician is unwilling to bill Medicare, Aetna becomes the primary payer and pays according to the schedule of benefits. You are responsible for all expenses not paid by Aetna.

	Participating Providers	Non-Participating Providers	Opt-Out Providers
Types of Medicare Providers	Agrees to accept the Medicare-approved amount as full payment for any Medicare-covered service. This is also referred to as a provider who "accepts assignment."	Agrees to accept Medicare, but not accept assignment.	Providers choose **not** to work with Medicare. Medicare will **not** pay for any covered items or services provided by opt-out providers, except in case of emergency or urgent (by their determination) need.
How Billing Works	Provider will bill Medicare; Medicare will pay the provider directly.	Provider may ask member to pay entire charge at time of service. Provider will usually bill Medicare but is not required to do so. In this case, member completes Patient Request for Payment (CMS 1490-s) form.	Provider will bill member directly. Neither member nor provider will receive reimbursement from Medicare.
How Fees Are Determined	Participating providers receive **80%** of the Medicare-approved amount after deductible is met.	Non-participating providers may charge up to **15% above** the Medicare approved amount for any Medicare-covered services (also called the *limiting charge*).	Opt-out providers are not governed in any way by Medicare set fees.

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Medicare Coordination of Benefits for the Aetna Choice POS II (PPO 90/70) (continued)

	Participating Providers	Non-Participating Providers	Opt-Out Providers
Coordination of Benefits Processing	When Medicare pays as primary for participating providers: 1) Provider submits claim to Medicare. 2) Medicare applies their benefit (80% of approved amount), sends payment and Explanation of Benefits (EOB) to provider. 3) Medicare electronically sends claim to Aetna. 4) Aetna pays any Medicare deductible. 5) Aetna pays provider directly, resulting in member having zero copay. *Example of coordination for a bill of $200.* ▪ *Medicare-allowed amount = $100.* ▪ *Medicare pays 80% of $100 = $80.* ▪ *Claim is received by Aetna with $20 left to pay.* ▪ *Aetna pays the $20.* ▪ *Summary: $80 Medicare payment + $20 Aetna payment = $100 which is the full allowed amount, provider writes off the other $100.*	When Medicare pays as primary for non-participating providers: 1) Provider can request payment up front if so desired. Provider is limited in amount they can collect to 15% over Medicare approved amount. 2) Generally, even if the provider requires payment up front, they will submit the claim to Medicare. If provider does not submit, then member sends paper claim to Medicare. 3) Medicare applies their benefit, sends payment and EOB to member. 4) Medicare electronically sends claim to Aetna. 5) Aetna pays any Medicare deductible. 6) Coordinate to the highest of Medicare or Aetna approved amount. – If the provider is a Choice POS II provider, Aetna pays provider directly. – If provider is not a Choice POS II provider, payment goes to member. – Member may have to pay the differential. *Example of coordination for a bill of $200:* ▪ *Medicare-allowed amount = $100.* ▪ *Medicare pays 80% of $100 = $80.* ▪ *Non-participating provider can bill 15% over Medicare-allowed amount, or up to $115.* ▪ *Claim is received by Aetna with $20 left to pay.* ▪ *Aetna pays the $20.* ▪ *Summary: $80 Medicare payment + $20 Aetna payment = $100 which is the full allowed amount. However, this non-participating provider can bill the member up to that extra 15%, so member could be billed $15.*	Process for opt-out Medicare providers: ▪ Provider can request payment in full, up front from member. ▪ Medicare will not pay for any services from opt-out providers. If provider is an **Aetna Choice POS II in-network provider** they are required to bill Aetna. When a claim is received by Aetna, Aetna pays the benefit as if Aetna is primary (i.e., as if no other plan was in place). Provider will send letter with claim confirming they have opted out of Medicare. *Example of coordination for a bill of $200:* ▪ *Aetna allowed amount = $100.* ▪ *Aetna pays 100% of $100. Aetna pays $100 to the provider.* ▪ *Summary: Since the provider is an Aetna Choice POS II provider, the most they can charge the member is $100. Member would owe the provider $0.* If provider is an **out-of-network provider**, they are not required to submit a bill to Aetna. 1) Member sends a paper claim to Aetna. Member will need letter from provider confirming they have opted-out of Medicare. 2) Aetna applies the Aetna-allowed amount to the claims and pays that amount directly to the member. 3) Member would be responsible for the full billed amount to provider. *Example of coordination for a bill of $200:* ▪ *Aetna allowed amount = $100.* ▪ *Summary: Aetna non-network pays 100% of $100. The $100 goes to the member. Member would owe the provider $200, which includes the $100 payment received from Aetna.*

Medicare HMO Plans

Plan Features	Health Maintenance Organization (HMO)	
	Aetna HMO MAP *Medicare (S05) HMO (MAP)*[1]	**Kaiser Permanente Senior Advantage**
	Network Only	*Network Only*
Annual Deductible: ▪ **Individual** ▪ **Family**	None	None
Annual Out-of-Pocket Maximum	$1,190 per individual	$1,190 per individual
Lifetime Maximum	None	None
Physician: ▪ **Office visits (including specialists)** ▪ **Urgent care** ▪ **Hospital visits** ▪ **Surgery**	 ▪ $30 copay each visit ▪ $30 copay each visit ▪ Covered under inpatient facility benefit ▪ Covered under outpatient surgery benefit	 ▪ $30 copay each visit ▪ $30 copay each visit ▪ $0 ▪ $0
Hospital: ▪ **Hospital per admission copay** ▪ **Inpatient care** ▪ **Outpatient surgery** ▪ **Skilled nursing facility**	 ▪ $250 per stay ▪ $250 per stay ▪ $0 ▪ $0 per day, days 1-100 (limited to 100 days per Medicare Benefit Period)	 ▪ $250 per stay ▪ $250 per stay ▪ $0 ▪ $20 per day up to 17 days; no charge for days 18 – 100; up to 100 days per benefit period
Emergency Room	$125 (waived if admitted)	$135 (waived if admitted)
Radiology (Outpatient)	$0	$0
Lab (Outpatient)	$0	$0
Ambulance	$0	$0
Rehabilitation ▪ **Physical, occupational, speech, cardiac** ▪ **Pulmonary**	 ▪ $30 copay each visit ▪ $20 copay each visit	$30 copay each visit
Behavioral Health: ▪ **Inpatient** ▪ **Outpatient**	 ▪ $250 per stay ▪ $30	 ▪ $250 per stay ▪ $30 copay each visit
Preventive Care[2]	$0	$0
Acupuncture (up to 30 visits per calendar year)	$30 (in lieu of anesthesia and for treatment of chronic pain)	$30 copay each visit
Allergy Testing/ Treatment	$30	$0

See footnotes on page 15.

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Medicare HMO Plans (continued)

Plan Features	Health Maintenance Organization (HMO)	
	Aetna HMO MAP *Medicare (S05) HMO (MAP)*[1]	**Kaiser Permanente Senior Advantage**
	Network Only	*Network Only*
Chiropractic Services	$20 copay each visit	$30 copay each visit (up to 30 visits per calendar year)
Durable Medical Equipment	$0	$0
Prescription Drugs[3] **(Closed Formulary)** ▪ **Maintenance medications** ▪ **Retail pharmacy** ▪ **Specialty pharmacy** ▪ **Mail-order pharmacy**	Annual out-of-pocket maximum: $1,810 per person For each prescription, you pay your coinsurance up to a maximum of $150 until you reach the annual out-of-pocket maximum (Express Scripts Medicare only) ▪ **Express Scripts:** 90-day supply when fulfilled through mail-order pharmacy or contracted retail pharmacy; **Kaiser:** 90-day supply when fulfilled through mail order or at a Kaiser facility ▪ Plan pays 90% for generic drugs and 80% for brand-name drugs purchased at retail pharmacies (up to a 34-day supply) ▪ Plan pays 90% for generic drugs and 80% for brand-name drugs purchased through the contracted specialty pharmacy (up to a 34-day supply) ▪ **Express Scripts Medicare:** Plan pays 95% for generic drugs and 80% for brand-name drugs purchased through the contracted mail-order pharmacy (up to a 90-day supply) ▪ **Kaiser Permanente:** Plan pays 90% for generic drugs and 80% for brand-name drugs purchased through the contracted mail-order pharmacy (up to a 90-day supply)	

[1] *Indicates Aetna plan name.*

[2] *Check with your plan for a complete list of covered preventive care services.*

[3] *Kaiser Permanente members must dispense prescriptions at a Kaiser facility.*

DENTAL COVERAGE

The following plans are available.

Dental Plan Type	Dental Plan Options	Availability
PPO	Delta Dental	Nationwide
HMO	Cigna Dental Care DHMO	Nationwide — with the exception of the following states: AK, ME, MT, ND, NH, NM, SD, VT, and WY

How PPO and HMO Dental Plans Work

PPO: The PPO Dental Plan is a fee-for-service plan. In other words, the Plan reimburses your covered expenses at a specified percentage, after you pay any applicable deductible. You may seek services from one of the many dentists who participate in the Delta Dental PPO Network or Delta Dental Premier Network, or from a non-participating dentist. When you seek services from a Delta Dental PPO dentist you receive the "In PPO network" benefit. Services from a Delta Dental Premier dentist or a non-participating dentist will be considered "Out of PPO Network." Delta Dental dentists agree not to charge above their accepted fee.

HMO: There is no annual deductible and most covered services require you to pay a flat dollar amount, known as a copay. You must select an in-network dental office to coordinate all of your care. All dental services must be received from your dental HMO's network of providers.

- *Geographic Service Area:* You and any covered dependents must live and receive dental care within the plan's geographic service area if you enroll in an HMO plan. Out-of-area dental services may not be covered, resulting in your financial responsibility for any costs incurred.

COMPARISON OF KEY DENTAL PLAN FEATURES

PPO and HMO Dental Plans

Plan Features	Delta Dental PPO		Cigna Dental Care DHMO[3]
	In PPO Network[1]	*Out of PPO Network*[2]	
Annual Deductible:			
▪ **Individual**	▪ $25/individual	▪ $50/individual	▪ None
▪ **Family**	▪ $75/family	▪ $150/family	▪ None
	▪ Deductibles not applicable to orthodontia and diagnostic/ preventive benefits	▪ Deductibles not applicable to orthodontia and diagnostic/ preventive benefits	
Annual Maximum Benefit	$2,750 (excludes orthodontia and diagnostic/preventive benefits)	$2,750 (excludes orthodontia and diagnostic/preventive benefits)	None for adults and children
Diagnostic/Preventive			
▪ **Oral exams (limited to two examinations per calendar year)**	▪ Plan pays 100% of PPO dentist's allowed fee (no deductible applies for these services and does not count toward the plan's annual maximum benefit)	▪ Plan pays 100% of Delta dentist's allowed fee[2] (no deductible applies for these services and does not count toward the plan's annual maximum benefit)	▪ Plan pays 100% after $5 copay
▪ **Teeth cleaning**	▪ Plan pays 100% of PPO dentist's allowed fee (no deductible applies for these services and does not count toward the plan's annual maximum benefit)	▪ Plan pays 100% of Delta dentist's allowed fee[2] (no deductible applies for these services and does not count toward the plan's annual maximum benefit)	▪ Plan pays 100% after $5 copay
	▪ 3 cleanings per calendar year	▪ 3 cleanings per calendar year	▪ 2 cleanings per calendar year
Basic Restorative Care:			
▪ **Basic fillings (amalgams, composites and sealants)**	▪ Plan pays 70% of PPO dentist's allowed fee	▪ Plan pays 70% of Delta dentist's allowed fee, after deductible[1]	▪ Plan pays 100%

See footnotes on page 18.

(continued)

PPO and HMO Dental Plans (continued)

Plan Features	Delta Dental PPO		Cigna Dental Care DHMO[3]
	In PPO Network[1]	*Out of PPO Network*[2]	
Major Restorative Care:			
▪ **Resin fillings (anterior and posterior)**	▪ Plan pays 70% of PPO contracted fees for Delta Dental PPO dentists	▪ Plan pays 70% of Premier contracted fees for Delta Dental Premier dentists and program allowance for non-Delta Dental dentists	▪ Plan pays 100%
▪ **Stainless steel crown**	▪ Plan pays 70% of PPO contracted fees for Delta Dental PPO dentists	▪ Plan pays 70% of Premier contracted fees for Delta Dental Premier dentists and program allowance for non-Delta Dental dentists	▪ Plan pays 100% after $8 copay for primary tooth; $12 copay for permanent tooth
▪ **Crowns, jackets and gold or cast restorations**	▪ Plan pays 70% of PPO contracted fees for Delta Dental PPO dentists	▪ Plan pays 70% of Premier contracted fees for Delta Dental Premier dentists and program allowance for non-Delta Dental dentists	▪ Plan pays 100% after a $100 copay
Orthodontia (adult and dependent children)	Plan pays 80% of PPO dentist's allowed fee (subject to a lifetime maximum of $2,000 per person)	Plan pays 80% of Delta dentist's allowed fee (subject to a lifetime maximum of $2,000 per person)	Plan pays 100% after a $380 copayment for banding. Adjustment post banding (child up to 19th birthday) $46 copayment, (adult) $67 copayment. Limited to one full case during lifetime; retreatment of orthodontic case is not covered.

[1] *Provider must be in the Delta Dental PPO network to be considered in-network. Delta Dental Premier network providers are considered "Non-PPO."*

[2] *If you use an out-of-network provider, claims are subject to program allowance, plan limits and established maximums.*

[3] *For a complete list of plan costs and features, refer to the complete Patient Charge Schedule on http://legacy.cigna.com/edison.*

VISION COVERAGE

The following plan is available through VSP.

How the Vision Plan Works

After a copay, the plan pays 100 percent of the contracted rate for regular eye exams received from in-network providers, and a portion of the cost for eyeglass frames and lenses or contact lenses according to the plan's schedule. You pay all amounts that exceed the plan allowances listed below.

Key Vision Plan Features

Vision Plan — Pre-1993

For retirees and survivors who became eligible for retiree health care in 1992 or earlier.

Plan Features	VSP Providers	Non-VSP Providers
Frequency of Service ▪ **Exams** ▪ **Lenses or contacts** ▪ **Frames**	▪ Once every 12 months ▪ Once every 24 months ▪ Once every 24 months	
Exam and/or Eyewear Copay	$20	$20
Comprehensive Eye Exam	Plan pays 100% after copay	Plan pays up to $35 allowance
Lenses ▪ **Single vision** ▪ **Bifocal** ▪ **Trifocal** ▪ **Standard Progressive**	 ▪ Plan pays 100% after copay ▪ Plan pays 100% after copay ▪ Plan pays 100% after copay ▪ Plan pays 100% after copay	 ▪ Plan pays up to $25 allowance ▪ Plan pays up to $40 allowance ▪ Plan pays up to $50 allowance ▪ Plan pays up to $50 allowance
Frames	Plan pays up to $105 allowance; 20% discount on any amount over the maximum allowance	Plan pays up to $30 allowance
Contact Lenses ▪ **Contacts (in lieu of prescription glasses)**	▪ Plan pays up to $100 allowance for contacts and contact lens exam (fitting and evaluation) ▪ 15% savings on contact lens exam (fitting and evaluation) ▪ 2nd pair coverage allows an additional pair of lenses or contact	▪ Plan pays up to $100 allowance
LASIK Surgery	Not covered	Not covered

Vision Plan — 1993 and After

For retirees and survivors who became eligible for retiree health care Jan. 1, 1993 or later.

Plan Features	VSP Providers	Non-VSP Providers
Frequency of Service ▪ **Exams** ▪ **Lenses or contacts** ▪ **Frames**	▪ Once every 12 months ▪ One pair — twice every 24 months ▪ Once every 24 months	
Exam and/or Eyewear Copay	$20	$20
Comprehensive Eye Exam	Plan pays 100% after copay	Plan pays up to $40 allowance
Lenses ▪ **Single vision** ▪ **Bifocal** ▪ **Trifocal** ▪ **Standard Progressive**	 ▪ Plan pays 100% after copay ▪ Plan pays 100% after copay ▪ Plan pays 100% after copay ▪ Plan pays 100% after copay	 ▪ Plan pays up to $40 allowance ▪ Plan pays up to $60 allowance ▪ Plan pays up to $80 allowance ▪ Plan pays up to $80 allowance
Frames	Plan pays up to $150 allowance; 20% discount on any amount over the maximum allowance	Plan pays up to $150 allowance
Contact Lenses ▪ **Contacts (in lieu of prescription glasses)**	▪ Plan pays up to $150 allowance for contacts and contact lens exam (fitting and evaluation) ▪ 15% savings on contact lens exam (fitting and evaluation) ▪ Additional Pairs of Eyewear: $150 allowance for contact lenses or second pair of standard lenses for glasses	▪ Plan pays up to $150 allowance
LASIK Surgery	Not covered	Not covered

CAUTION! Dental and Vision Plan Coverage

- You will not be able to enroll in our dental and/or vision plans in the future if you waive dental and/or vision coverage and do not have group coverage elsewhere. If you have other group coverage, you **must** notify the *EIX Benefits Connection* **before** you waive so that you don't lose future eligibility.
- If your coverage is canceled for nonpayment, you will not be allowed to enroll in our dental and/or vision plans in the future.

IF YOU HAVE QUESTIONS

Contact your health plan carrier directly by going to the *EIX Benefits Connection* website, eixbenefits.com, at **Health > Health & Welfare > More > Contacts & Helpful Info** to see all carrier phone numbers and website addresses.

For general questions about your benefits, contact the *EIX Benefits Connection* at 866-693-4947. Representatives are available Monday through Friday, 7:30 a.m. to 5:30 p.m., Pacific time, except holidays.

CONTACTS AND HELPFUL INFORMATION

	Plan Type	Plan Identifier on ID Card	Phone Number	Website
Pre-Medicare Health Plans	Aetna Nationwide EPO	▪ Actives & Flex Retirees: *Open Access Aetna Select* ▪ PrimeCare Retirees: *Open Access Aetna Select (100%)*	(833) 541-8555	aetnaresource.com/n/Edison
	Aetna PPO 90/70	▪ Actives & Flex Retirees: *Choice POS II (PPO 90/70)* ▪ PrimeCare Retirees: *Choice POS II (100%)*	(833) 541-8555	aetnaresource.com/n/Edison
	Kaiser Permanente EPO	—	(800) 533-1833 (So CA) (800) 663-1771 (No CA)	https://choose.kaiserpermanente.org/edison
Pre-Medicare Prescription Drug Coverage	Express Scripts — *for all Aetna plans*	—	(877) 620-6730	www.express-scripts.com
	Kaiser Permanente EPO	—	(800) 533-1833 (So CA) (800) 663-1771 (No CA)	https://choose.kaiserpermanente.org/edison
Medicare Health Plans	Aetna HMO MAP	▪ Flex Retirees: *Medicare (S05) HMO (MAP)* ▪ PrimeCare Retirees: *Medicare (P01) HMO (MAP 100%)*	(833) 943-5114	SCEMAPlans.aetnamedicare.com
	Aetna PPO MAP	▪ Flex Retirees: *Medicare (S02) ESA PPO (MAP)* ▪ PrimeCare Retirees: *Medicare (C04) ESA PPO (MAP 100%)*	(833) 943-5114	SCEMAPlans.aetnamedicare.com
	Aetna PPO Medicare Coordinated Plan	▪ Flex Retirees: *Choice POS II (PPO 90/70)* ▪ PrimeCare Retirees: *Choice POS II (100%)*	(833) 541-8555	www.aetnaresource.com/n/EdisonMC
	Kaiser Permanente Senior Advantage MAP	—	(800) 443-0815	https://choose.kaiserpermanente.org/edison
Medicare Prescription Drug Coverage	Express Scripts Medicare — *for Medicare Retirees in an Aetna plan*	—	(800) 978-6230	www.express-scripts.com
	Kaiser Permanente Senior Advantage MAP	—	(800) 443-0815	https://choose.kaiserpermanente.org/edison
Dental Plans	Cigna Dental Care DHMO	—	(800) 244-6224	http://legacy.cigna.com/edison
	Delta Dental PPO	—	(888) 335-8227	www.deltadentalins.com/edison
Vision Plan	Vision Service Plan	—	(800) 877-7195	www.vsp.com

- For assistance with Medicare enrollment or evaluating plans offered outside of Edison, contact SSDC (866) 587-1661.
- For assistance finding providers, understanding coverage, and resolving insurance issues, contact Health Advocate at (866) 695-8622 or visit healthadvocate.com/edison.