



2024 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. 23 through Nov. 3, 2023

**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	Kaiser Permanente	In California only

Medical Plan Options — Medicare		
Plan	Prescription Drug Coverage	Availability
Aetna HMO MAP	Express Scripts Medicare	Available in select counties throughout the U.S.
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

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.

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 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, 2024.

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
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

See footnotes on page 6.

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Pre-Medicare Plans
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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
Hospital:				
<ul style="list-style-type: none"> ▪ Hospital per admission copay ▪ Outpatient surgery ▪ Skilled nursing facility 	<ul style="list-style-type: none"> ▪ \$250 copay ▪ Plan pays 90% after deductible ▪ \$250 copay and Plan pays 90% after deductible (up to 100 days/calendar year) 	<ul style="list-style-type: none"> ▪ Plan pays 70% after deductible ▪ Plan pays 70% after deductible ▪ \$250 copay and Plan pays 90% after deductible (up to 100 days/calendar year) 	<ul style="list-style-type: none"> ▪ \$250 per admission copay ▪ No copay ▪ \$250 per admission copay (up to 100 days/calendar year) 	<ul style="list-style-type: none"> ▪ \$250 per admission copay ▪ No copay ▪ \$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
Behavioral Health:				
<ul style="list-style-type: none"> ▪ Inpatient ▪ Outpatient 	<ul style="list-style-type: none"> ▪ \$250 copay and Plan pays 90% after deductible ▪ \$40 copay each visit 	<ul style="list-style-type: none"> ▪ Plan pays 70% after deductible ▪ Plan pays 70% after deductible 	<ul style="list-style-type: none"> ▪ \$250 per admission copay ▪ \$30 copay each visit 	<ul style="list-style-type: none"> ▪ \$250 per admission copay ▪ \$30 copay each visit
Preventive Care²	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

See footnotes on page 6.

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Pre-Medicare Plans
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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
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			
<ul style="list-style-type: none"> ■ Retail pharmacy ■ Specialty pharmacy ■ Mail order pharmacy 	<ul style="list-style-type: none"> ■ 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) ■ 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, 2024.

Plan Features	Preferred Provider Organization (PPO)			
	Aetna PPO 90/70 Medicare Coordinated Plan Choice POS II (PPO 90/70) ¹		Aetna PPO MAP Medicare (S02) ESA PPO (MAP) ¹	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible:				
▪ Individual	\$575		None	
▪ Family	\$1,150			
Annual Out-of-Pocket Maximum	\$3,000/individual \$6,000/family		\$3,000/individual	
Lifetime Maximum	None		None	
Physician:				
▪ Office visits (including specialists)	▪ \$40 copay each visit	▪ Plan pays 70% after deductible	▪ \$40 copay each visit	
▪ Urgent care	▪ \$40 copay each visit	▪ Plan pays 70% after deductible	▪ \$40 copay each visit	
▪ Hospital visits	▪ Plan pays 90% after deductible	▪ Plan pays 70% after deductible	▪ Covered under inpatient facility benefit	
▪ Surgery	▪ Plan pays 90% after deductible	▪ Plan pays 70% after deductible	▪ \$0	

See footnotes on page 9.

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Medicare PPO Plans
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Plan Features	Preferred Provider Organization (PPO)			
	Aetna PPO 90/70 Medicare Coordinated Plan Choice POS II (PPO 90/70) ¹		Aetna PPO MAP Medicare (S02) ESA PPO (MAP) ¹	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospital: <ul style="list-style-type: none"> ▪ Hospital per admission copay ▪ Inpatient care ▪ Outpatient surgery ▪ Skilled nursing facility 	<ul style="list-style-type: none"> ▪ \$250 per admission copay ▪ Plan pays 90% after deductible ▪ Plan pays 90% after deductible ▪ \$0 per day, days 1-100 (limited to 100 days per Medicare Benefit Period) ▪ \$250 copay and Plan pays 90% after deductible (up to 100 days/calendar year) 	<ul style="list-style-type: none"> ▪ None ▪ Plan pays 70% after deductible ▪ Plan pays 70% after deductible ▪ \$0 per day, days 1-100 (limited to 100 days per Medicare Benefit Period) ▪ \$250 copay and Plan pays 90% after deductible (up to 100 days/calendar year) 	<ul style="list-style-type: none"> ▪ \$250 per stay ▪ \$0 ▪ \$0 ▪ \$0 per day, days 1-100 (limited to 100 days per Medicare Benefit Period) 	
Emergency Room	\$150 copay (applies to hospital emergency room charges only; copay waived if admitted as an inpatient)		\$125 (waived if admitted)	
Radiology (Outpatient)	Plan pays 90% after deductible	Plan pays 70% after deductible	\$0	
Lab (Outpatient)	Plan pays 90% after deductible	Plan pays 70% after deductible	\$0	
Ambulance	Plan pays 90% after deductible	Plan pays 70% after deductible	\$0	
Rehabilitation (physical, occupational, speech, pulmonary, cardiac)	Plan pays 90% after deductible	Plan pays 70% after deductible	\$40 (\$20 for pulmonary rehabilitation)	
Behavioral Health: <ul style="list-style-type: none"> ▪ Inpatient ▪ Outpatient 	<ul style="list-style-type: none"> ▪ \$250 copay and plan pays 90% after deductible ▪ \$40 copay each visit 	<ul style="list-style-type: none"> ▪ Plan pays 70% after deductible ▪ Plan pays 70% after deductible 	<ul style="list-style-type: none"> ▪ \$250 per stay ▪ \$40 	

See footnotes on page 9.

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Medicare PPO Plans
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Plan Features	Preferred Provider Organization (PPO)			
	Aetna PPO 90/70 Medicare Coordinated Plan Choice POS II (PPO 90/70) ¹		Aetna PPO MAP Medicare (S02) ESA PPO (MAP) ¹	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care ²	No charge, deductible waived	Plan pays 70% after deductible	No charge	
Acupuncture (up to 30 visits per calendar year)	\$40 copay each visit	Plan pays 70% after deductible	\$40	
Allergy Testing/Treatment	\$40 copay each visit	Plan pays 70% after deductible	\$40	
Chiropractic Services (up to 30 visits per calendar year)	\$40 copay each visit	Plan pays 70% after deductible	\$20	
Durable Medical Equipment	Plan pays 90% after deductible	Plan pays 70% after deductible	\$0	
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)			
<ul style="list-style-type: none"> ■ Retail pharmacy ■ Specialty pharmacy ■ Mail order pharmacy 	<ul style="list-style-type: none"> ■ 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.

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	None	None
▪ Family		
Annual Out-of-Pocket Maximum	\$1,190 per individual	\$1,190 per individual
Lifetime Maximum	None	None
Physician:		
▪ Office visits (including specialists)	▪ \$30 copay each visit	▪ \$30 copay each visit
▪ Urgent care	▪ \$30 copay each visit	▪ \$30 copay each visit
▪ Hospital visits	▪ Covered under inpatient facility benefit	▪ \$0
▪ Surgery	▪ Covered under outpatient surgery benefit	▪ \$0
Hospital:		
▪ Hospital per admission copay	▪ \$250 per stay	▪ \$250 per stay
▪ Inpatient care	▪ \$250 per stay	▪ \$250 per stay
▪ Outpatient surgery	▪ \$0	▪ \$0
▪ Skilled nursing facility	▪ \$0 per day, days 1-100 (limited to 100 days per Medicare Benefit Period)	▪ \$20 per day up to 17 days; no charge for days 10-100; 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

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Medicare HMO Plans
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Plan Features	Health Maintenance Organization (HMO)	
	Aetna HMO MAP Medicare (S05) HMO (MAP) ¹	Kaiser Permanente Senior Advantage
	Network Only	Network Only
Rehabilitation <ul style="list-style-type: none"> Physical, occupational, speech, cardiac Pulmonary 	<ul style="list-style-type: none"> \$40 copay each visit \$20 copay each visit 	\$30 copay each visit
Behavioral Health: <ul style="list-style-type: none"> Inpatient Outpatient 	<ul style="list-style-type: none"> \$250 per stay \$30 	<ul style="list-style-type: none"> \$250 per stay \$30 copay each visit
Preventive Care²	\$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
Chiropractic Services	\$20 copay each visit	\$30 copay each visit (up to 30 visits per calendar year)
Durable Medical Equipment	\$0	\$0
Prescription Drugs³ (Closed Formulary) <ul style="list-style-type: none"> 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) <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> ▪ Individual ▪ Family 	<ul style="list-style-type: none"> ▪ \$25/individual ▪ \$75/family ▪ Deductibles not applicable to orthodontia and diagnostic/preventive benefits 	<ul style="list-style-type: none"> ▪ \$50/individual ▪ \$150/family ▪ Deductibles not applicable to orthodontia and diagnostic/preventive benefits 	<ul style="list-style-type: none"> ▪ None ▪ None
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 <ul style="list-style-type: none"> ▪ Oral exams (limited to two examinations per calendar year) ▪ Teeth cleaning 	<ul style="list-style-type: none"> ▪ 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 PPO dentist's allowed fee (no deductible applies for these services and does not count toward the plan's annual maximum benefit) ▪ 3 cleanings per calendar year 	<ul style="list-style-type: none"> ▪ Plan pays 100% of Delta dentist's allowed fee² (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 fee² (no deductible applies for these services and does not count toward the plan's annual maximum benefit) ▪ 3 cleanings per calendar year 	<ul style="list-style-type: none"> ▪ Plan pays 100% after \$5 copay ▪ Plan pays 100% after \$5 copay ▪ 2 cleanings per calendar year
Basic Restorative Care: <ul style="list-style-type: none"> ▪ Basic fillings (amalgams, composites and sealants) 	<ul style="list-style-type: none"> ▪ Plan pays 70% of PPO dentist's allowed fee 	<ul style="list-style-type: none"> ▪ Plan pays 70% of Delta dentist's allowed fee, after deductible¹ 	<ul style="list-style-type: none"> ▪ Plan pays 100%

See footnotes on page 14.

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PPO and HMO
Dental Plans
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Plan Features	Delta Dental PPO		Cigna Dental Care DHMO ³
	In PPO Network ¹	Out of PPO Network ²	
Major Restorative Care: <ul style="list-style-type: none"> ▪ Resin fillings (anterior and posterior) ▪ Stainless steel crown ▪ Crowns, jackets and gold or cast restorations 	<ul style="list-style-type: none"> ▪ Plan pays 70% of PPO contracted fees for Delta Dental PPO dentists ▪ Plan pays 70% of PPO contracted fees for Delta Dental PPO dentists ▪ Plan pays 70% of PPO contracted fees for Delta Dental PPO dentists 	<ul style="list-style-type: none"> ▪ Plan pays 70% of Premier contracted fees for Delta Dental Premier dentists and program allowance for non-Delta Dental dentists ▪ Plan pays 70% of Premier contracted fees for Delta Dental Premier dentists and program allowance for non-Delta Dental dentists ▪ Plan pays 70% of Premier contracted fees for Delta Dental Premier dentists and program allowance for non-Delta Dental dentists 	<ul style="list-style-type: none"> ▪ Plan pays 100% ▪ Plan pays 100% after \$8 copay for primary tooth; \$12 copay for permanent tooth ▪ 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 mycigna.com.

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

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

Vision Plan — Pre-1993

Plan Features	VSP Providers	Non-VSP Providers
Frequency of Service <ul style="list-style-type: none"> ▪ Exams ▪ Lenses or contacts ▪ Frames 		<ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> ▪ Single vision ▪ Bifocal ▪ Trifocal ▪ Standard Progressive 	<ul style="list-style-type: none"> ▪ Plan pays 100% after copay 	<ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> ▪ Contacts (in lieu of prescription glasses) 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> ▪ Exams ▪ Lenses or contacts ▪ Frames 		<ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> ▪ Single vision ▪ Bifocal ▪ Trifocal ▪ Standard Progressive 	<ul style="list-style-type: none"> ▪ Plan pays 100% after copay 	<ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> ▪ Contacts (in lieu of prescription glasses) 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> Actives & Flex Retirees: <i>Open Access Aetna Select</i> PrimeCare Retirees: <i>Open Access Aetna Select (100%)</i> 	(833) 541-8555	aetnaresource.com/n/Edison
	Aetna PPO 90/70	<ul style="list-style-type: none"> Actives & Flex Retirees: <i>Choice POS II (PPO 90/70)</i> PrimeCare Retirees: <i>Choice POS II (100%)</i> 	(833) 541-8555	aetnaresource.com/n/Edison
	Kaiser Permanente EPO	—	(800) 533-1833 (So CA) (800) 663-1771 (No CA)	my.kp.org/edison
Pre-Medicare Prescription Drug Coverage	Express Scripts — <i>for all Aetna plans</i>	—	(877) 620-6730	www.express-scripts.com/southerncaliforniaedison
	Kaiser Permanente EPO	—	(800) 533-1833 (So CA) (800) 663-1771 (No CA)	my.kp.org/edison
Medicare Health Plans	Aetna HMO MAP	<ul style="list-style-type: none"> Flex Retirees: <i>Medicare (S05) HMO (MAP)</i> PrimeCare Retirees: <i>Medicare (P01) HMO (MAP 100%)</i> 	(833) 541-8555	SCEMAPPlans.aetnamedicare.com
	Aetna PPO MAP	<ul style="list-style-type: none"> Flex Retirees: <i>Medicare (S02) ESA PPO (MAP)</i> PrimeCare Retirees: <i>Medicare (C04) ESA PPO (MAP 100%)</i> 	(833) 541-8555	SCEMAPPlans.aetnamedicare.com
	Aetna PPO Medicare Coordinated Plan	<ul style="list-style-type: none"> Flex Retirees: <i>Choice POS II (PPO 90/70)</i> PrimeCare Retirees: <i>Choice POS II (100%)</i> 	(833) 541-8555	SCEMAPPlans.aetnamedicare.com
	Kaiser Permanente Senior Advantage MAP	—	(800) 443-0815	my.kp.org/edison
Medicare Prescription Drug Coverage	Express Scripts Medicare — <i>for Medicare Retirees in an Aetna plan</i>	—	(800) 978-6230	www.express-scripts.com
	Kaiser Permanente Senior Advantage MAP	—	(800) 443-0815	my.kp.org/edison
Dental Plans	Cigna Dental Care DHMO	—	(800) 244-6224	www.cigna.com/edison
	Delta Dental PPO	—	(888) 335-8227	www.deltadentalins.com/edison
Vision Plan	Vision Service Plan	—	(800) 877-7195	www.vsp.com